

# EMERGENCY CARD

(This card needs to be completed every school year.)

Student Address Label

School \_\_\_\_\_ Date \_\_\_\_\_

Grade \_\_\_\_\_ Room \_\_\_\_\_ Language Spoken at Home \_\_\_\_\_

Name \_\_\_\_\_ Sex: M  F  Birthdate 

Month			Day			Year			

(Last)

(First)

(Middle Initial)

Month

Day

Year

Home Address \_\_\_\_\_ Apt. No. \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address \_\_\_\_\_ Zip Code \_\_\_\_\_ Child resides with \_\_\_\_\_

Father's/Legal Guardian's Name:

Employer: \_\_\_\_\_

Active Duty: Yes  No  Branch of Military Service: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Cellular Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Mother's/Legal Guardian's Name:

Employer: \_\_\_\_\_

Active Duty: Yes  No  Branch of Military Service: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Cellular Phone: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

**EMERGENCY CONTACTS:** In case child listed above becomes ill or is injured at school and I cannot be contacted, the school authorities have my permission to contact and release my child to the custody of one of the following:

**Name**

**Relationship**

**Phone**

1. \_\_\_\_\_

2. \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_ Dentist \_\_\_\_\_ Phone \_\_\_\_\_

If my child needs to be taken to an emergency facility, he/she will be taken to the nearest one.

To assure prompt attention to your child,

**PLEASE NOTIFY SCHOOL OF ANY CHANGE IN PHONE NUMBER OR ADDRESS.**

Parent's/Legal Guardian's Signature

**Note: Please complete health information on back of card. ➔**

**INSURANCE INFORMATION:**

My child has health insurance:  Yes  No If YES, check:  QUEST/Medicaid **OR**  Private  
If private, check your plan:  HMSA  Kaiser  Tri-Care  Other \_\_\_\_\_

**MEDICAL CONDITIONS:**

- My child does not have any medical conditions.
- My child has a medical condition(s).

**Please check below:**

- Asthma
- Chronic Cough/Wheezing
- Hearing Problems
- Seizures
- Blood Disorders
- Diabetes Type I
- Heart Condition
- Skin Problems
- Bone/Joint Disorders
- Diabetes Type II
- High Blood Pressure
- Vision Problems
- Cancer/Leukemia
- Genetic Condition
- Metabolic Disorder
- Other \_\_\_\_\_

- ALLERGIES:**  Bee Sting  Food  Medications  Other \_\_\_\_\_

For the above allergy(ies), reaction occurs by:  Skin contact  By inhalation  By ingestion  Other \_\_\_\_\_

Date of last reaction: \_\_\_\_\_

Describe the allergic reaction that occurs: \_\_\_\_\_

- MEDICATION(S) TAKEN:**

My child takes the following medication(s): \_\_\_\_\_

Reason for taking the medication(s): \_\_\_\_\_

- OTHER HEALTH CONCERNS:** \_\_\_\_\_

Other children:	Name	School	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____