

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_

Date of Birth \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_

With whom does the child reside? \_\_\_\_\_

Parent 1 \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_

Parent 2 \_\_\_\_\_ Daytime Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Email \_\_\_\_\_

Name of local person, other than the parent or guardian, to call in case of emergency. \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_

Name of Physician to call in case of emergency \_\_\_\_\_

Phone \_\_\_\_\_

Name of Dentist to call in case of emergency \_\_\_\_\_

Phone \_\_\_\_\_

In case of emergency, which hospital would you prefer? \_\_\_\_\_

Does your child have any allergies?  Yes  No

If yes, please list: \_\_\_\_\_

Does your child have any medication allergies?  Yes  No

If yes, please list: \_\_\_\_\_

Does your child have any allergies to bees or insects?  Yes  No

If yes, please list: \_\_\_\_\_

Does your child take medication regularly at home?  Yes  No

If yes, please list: \_\_\_\_\_

Does your child wear glasses?  Yes  No

Does your child wear contact lenses?  Yes  No

Does your child have any significant medical conditions or problems we should know about?  Yes  No

i.e. any serious accident or illness, operations \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To Whom It May Concern: I give consent for my child, \_\_\_\_\_, to be treated medically in an emergency.

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_