Emergency Contact Form

Child's First Name:_____**Last Name:**_____

Date of Birth: ___/___/___ **Parents or Guardian's Name(s):** _____

Address: _____**Home Phone #:** _____

Mother's Work Phone #_____**Father's Work Phone#:** _____

Mother's Cell# _____**Father's Cell Phone#:**_____

Family Email: _____

Person(s) authorized to pick up your child / Emergency Contacts: **(Person must show picture I.D.)**

Name:_____ Relationship: _____ Phone#:_____
Name:_____ Relationship: _____ Phone#:_____
Name:_____ Relationship: _____ Phone#:_____
Name:_____ Relationship: _____ Phone#:_____

Is your child under medical care or taking any medication(s)? □ Yes □ No
If yes, please check all of the following conditions that your child has and indicate if medication needs to be dispensed at school?

□ Bee Sting Allergy Epi-pen □ Yes □ No □ Other Allergies: _____
□ Asthma Inhaler □ Yes □ No
□ Diabetes Insulin □ Yes □ No
□ Vision / Hearing Glasses □ Yes □ No

Family Health Care: Physician's Name:_____ Phone #:_____

Parent or Guardian Signature:_____ **Date:**_____