## **EMERGENCY INFORMATION CARD**

## Student Name:\_ Grade: \_\_\_\_\_ Student Name:\_ Grade: \_\_\_\_\_ First First Last Last Address:\_ Address:\_ Phone: Phone: Phone: \_ Phone: \_\_ List two nearby emergency contacts who will assume temporary care of your child if you cannot be List two nearby emergency contacts who will assume temporary care of your child if you cannot be reached. reached. 1. Name:\_\_ Phone: \_\_\_ 1. Name:\_\_\_\_ Phone: \_\_ Phone: Phone: (Complete Reverse Side ---->) (Complete Reverse Side ---->)

## **EMERGENCY INFORMATION CARD**

Student Name:_			Grade:					
	Last	First						
Address:				A				
Parent 1 Name:_		Phone	:	Pa				
Parent 2 Name: _		Phone	:	Pa				
List two nearby emergency contacts who will assume temporary care of your child if you cannot be								
reached.								
1. Name:		Phone	:	1.				
2. Name:		Phone	:	2.				

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Student Name:		Grade:	
Last	First		
Address:			
Parent 1 Name:	Phone	ə:	
Parent 2 Name:	Phone	e:	
List two nearby emergency co	ontacts who will assume temporary care reached.	of your child if you cannot be	
1. Name:	Phone	ə:	
2. Name:	Phone	e:	

(Complete Reverse Side ---->)

(Complete Reverse Side ---->)

In case of accident or serious illness, I request the school/coach to contact me. If the school/coach is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow their instructions. If it is impossible to contact this physician, I hereby authorize any licensed physician to render necessary treatment. I will assume all financial responsibility for injuries or illness sustained by my child. In case of an emergency, if I cannot be located, I authorize school authorities to arrange for ambulance services.

Signature of parent or guardian	Date:	Signature of parent or guardian	Date:	
Medical Insurance Co	Policy/Group #:	Medical Insurance Co.	Policy/Group #:	
Allergies/Allergic Reactions:		Allergies/Allergic Reactions:		
List Medications your child is taking:		List Medications your child is taking:		
Other Medical Conditions:		Other Medical Conditions:		
Physician's Name:	Phone:	Physician's Name:	Phone:	
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Signature of parent or guardian	Date:	Signature of parent or guardian	Date:	
Medical Insurance Co	Policy/Group #:	Medical Insurance Co.	Policy/Group #:	
Allergies/Allergic Reactions:		Allergies/Allergic Reactions:		
List Medications your child is taking:		List Medications your child is taking:		
Other Medical Conditions:		Other Medical Conditions:		
Physician's Name:	Phone:	Physician's Name:	Phone:	

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