Student Emergency / Medical Contact Information

Child #1's Name Age Date of Birth

Child #2's Name Age Date of Birth

Child #3's Name Age Date of Birth

Parent/Guardian #1 E-mail

Parent/Child Address

City Zip Home Phone #

Cell # Work Phone #

Parent/Guardian #2 E-mail

Cell # Work Phone #

Address

Immunization Record Please check one of the following:

☐ I have provided a copy of my child's most current immunization record

OR

☐ My child's immunization record is up-to-date and is filed at the public school, _____.
(School Name)

Medication List any medication your child is currently taking. (We do not administer medication; for medical info only.)

Does your child have any illnesses or injuries that may affect him/her at the academy? If so, please explain below:

_____

List the name, address, and telephone number of the child's physician or an emergency care facility_____

_____

Allergies ☐ Yes ☐ No If you checked yes, you must describe allergy and treatment below.
Allergy:_____ Symptoms/management _____

Dietary restrictions ☐ Yes ☐ No If this box is checked, we will make every attempt to work within your child's specific dietary restriction. My child has the following dietary restrictions: _____

Other helpful information Please describe any other information which may be helpful to staff (i.e., special needs, fears, behaviors, etc.). If there is any additional information about your child that you would like to communicate, please attach written information to this form.

Parent/Guardian Signature Date

06/13/14