



Homerroom: _____

Grade: _____

OFFICE/HEALTH EMERGENCY FORM

Student Name: _____ Date of Birth: ___ / ___ / ___

Address: _____
Street Apt # City State Zip

Mother's Name: _____ Home Phone: _____

Mother's Employer: _____ Work Phone: _____

Father's Name: _____ Home Phone: _____

Father's Employer: _____ Work Phone: _____

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

Primary Language at Home: _____ Religion: _____

Please list the full name(s) and grade(s) of all siblings that attend the Academy:

In case of emergency, please list two responsible adults to contact if parents cannot be reached.

Emergency Contact 1: _____ Emergency Contact 2: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Name of Insurance Company: _____ Policy Number: _____

Doctor's Name: _____ Phone: _____

Hospital/ Health Center where you take your child when he/she is ill:

Name: _____ Phone: _____

Address: _____
Street Apt # City State Zip

If emergency medical attention is necessary and we cannot reach you, do you authorize school staff to initiate medical treatment?

YES _____ NO _____

Does your child have any health problems of which the Academy should be aware? Please describe:

Does your child take daily medication? YES _____ NO _____ If yes, please state below:

Name of Medication: _____ Time(s) taken: _____

Allergies: Food: _____ Medication(s): _____

Known vision problems: YES _____ NO _____ Glasses: Always _____ Part time _____ Never _____

Known hearing problems: YES _____ NO _____ Hearing Aid: YES _____ NO _____

Are there currently any custody issues of which the school should be aware? If so, please explain:

Is there any additional information of which the school should be aware? If so, please explain:

I hereby authorize the release of the above information that the school deems appropriate for the coordination of services to my child. YES _____ NO _____

Parent/Guardian Signature: _____ Date _____