

# EMERGENCY INFORMATION FORM

Students Name: \_\_\_\_\_

Students Home Address: \_\_\_\_\_

\_\_\_\_\_

Emergency contact for parents, guardian, family members and  
Friend who are picking up.

Name: \_\_\_\_\_

Work: \_\_\_\_\_

Home: \_\_\_\_\_

Cell phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Name: \_\_\_\_\_

Work: \_\_\_\_\_

Home: \_\_\_\_\_

Cell phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Name: \_\_\_\_\_

Work: \_\_\_\_\_

Home: \_\_\_\_\_

Cell phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Name: \_\_\_\_\_

Work: \_\_\_\_\_

Home: \_\_\_\_\_

Cell phone: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Relationship to student: \_\_\_\_\_

Child's physician name and phone Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Please provide a copy of your insurance card with this application.

Does your child have health condition(s), which may require  
EMERGENCY ACTION (e.g., seizures, asthma, allergies, diabetes,  
etc)? If "yes", Please describe,

\_\_\_\_\_  
\_\_\_\_\_

Please provide copy of your child immunization (shot records)