

2018-2019 Emergency Contact Form

One form must be completed per student

Date: _____

Grade Entering _____

Student Information

First Name: _____ Middle _____ Last _____

Student's Birthday: _____ Gender: M / F

Student's Address: _____ City: _____ Zip: _____

Home Phone: _____ Email Address: _____

Lives with: ___ Mother/Father ___ Mother/Stepfather ___ Father/Stepmother ___ Mother ___ Father ___ Other
Any court ordered custody issues must be clearly stated in current court papers, please attach a copy.

Emergency Contact _____ Home Phone # _____ Cell Phone # _____
(other than parent and local)

Parent Information

Father's Name:

Daytime Telephone Number:

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Employer's Name: _____ City: _____

Mother's Name:

Daytime Telephone Number:

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Employer's Name: _____ City: _____

Step-Parent/Guardian Name:

Daytime Telephone Number:

Address: _____ City: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Employer's Name: _____ City: _____

Medical and Dental Insurance Information

Student's Weight: _____ **Student's Height** _____

Doctor/Pediatrician Name: _____ **Phone** _____

Address: _____ **City:** _____ **Zip** _____

Name of Insurance Co.: _____

Group Policy: _____ **Member #:** _____

Hospital: _____

Dentist Name: _____ **Phone** _____

Address: _____ **City:** _____ **Zip:** _____

Name of Insurance Co.: _____

Group Policy _____ **Member #:** _____

Hospital: _____

Medical / Allergy Information

Does the student have any medical conditions? _____

If yes, is it life threatening? _____

Does the student have any food allergies? _____

If yes, list instructions for treatment: _____

Is the student allergic to bee stings? Yes / No Personal Epi-Pen on site?: Yes / No

I give permission for the staff of HCS to administer the following over-the-counter medications as needed according to the recommended dosage chart for weight and age:

Tylenol Motrin/Ibuprofen Benadryl

Carpool Information

I give permission for the following people to pick my student(s) up from school: _____

I/ we declare that all the information given is true and correct.

Father's / Guardian's Signature

Date

Mother's / Guardian's Signature

Date