



EMERGENCY CONTACT and HEALTH HISTORY FORM

Family Name:

Address: \_\_\_\_\_ School Year: 2016-2017

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_ First Contact : Father Mother

Father (full name): \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother (full name): \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

In case of an emergency, and you cannot be reached, list 2 people to contact.

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

I authorize the school to seek immediate emergency medical treatment at their discretion. YES NO

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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Student Information

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Glasses Y N Contacts Y N

Allergies: Y N if Yes, please specify Medications: \_\_\_\_\_

Food: \_\_\_\_\_ Other: \_\_\_\_\_

Asthma: Y N Inhaler name: \_\_\_\_\_ Medicates self Y N

ADD/ADHA/Autism Spectrum: Y N Medically treated: Y N Medication: \_\_\_\_\_

Diabetes: Y N Migraines: Y N Seizures: Y N Other Conditions:

\_\_\_\_\_

Medications your child takes regularly: \_\_\_\_\_

Please note that this information may be shared with faculty/staff/emergency personnel. Please add additional children on the back.

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Glasses Y N Contacts Y N

Allergies: Y N if Yes, please specify Medications: \_\_\_\_\_

Food: \_\_\_\_\_ Other: \_\_\_\_\_

Asthma: Y N Inhaler name: \_\_\_\_\_ Medicates self Y N

ADD/ADHA/Autism Spectrum: Y N Medically treated: Y N Medication: \_\_\_\_\_

Diabetes: Y N Migraines: Y N Seizures: Y N Other Conditions:

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Medications your child takes regularly: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Glasses Y N Contacts Y N

Allergies: Y N if Yes, please specify Medications: \_\_\_\_\_

Food: \_\_\_\_\_ Other: \_\_\_\_\_

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Diabetes: Y N Migraines: Y N Seizures: Y N Other Conditions:

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Medications your child takes regularly: \_\_\_\_\_

**Where Children Grow In Wholeness and Holiness**

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