

2024-2025 STUDENT EMERGENCY CONTACT/HEALTH FORM

Please Complete One Form for Each Child in Your Family

STUDENT NAME: _____

EMERGENCY CONTACTS: (Must list at least one)

NAME: _____ RELATION: _____ PHONE: _____

NAME: _____ RELATION: _____ PHONE: _____

AFTERSCHOOL CARE PROVIDER _____
NAME ADDRESS & PHONE

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**DOCTOR PREFERRED** \_\_\_\_\_  
**IN EMERGENCY** NAME ADDRESS & PHONE

**DENTIST PREFERRED** \_\_\_\_\_  
**IN EMERGENCY** NAME ADDRESS & PHONE

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PLEASE LIST ANY MEDICAL CONDITIONS THAT THE SCHOOL SHOULD BE AWARE OF:

ALLERGIES: _____

CURRENT MEDICATIONS: _____

DOES YOUR CHILD WEAR: GLASSES? _____ **CONTACTS?** _____