



**EMERGENCY &
OFF GROUNDS
INFORMATION
(One form per child)**

IMPORTANT! PLEASE CALL OFFICE WITH ANY UPDATES.

Student's Name	Grade	Date of Birth	Today's Date
Parent's/Guardian's Name			
Home Address	Home Phone		
	Father/Guardian Cell		
	Mother/Guardian Cell		
Father/Guardian Employer			
Business Hours		Business Phone	
Mother/Guardian Employer			
Business Hours		Business Phone	
Person to contact if parents are not available. <i>(List someone locally. This must be filled out.)</i>			
Name		Relationship	
Address		Phone	
Does your child have any unusual health conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If YES, please indicate:			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Surgical	<input type="checkbox"/> Bee sting allergy	<input type="checkbox"/> Internal irregularity
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Heart	<input type="checkbox"/> Other allergy <i>(list)</i>	<input type="checkbox"/> Sight impairment (describe):
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Fractures	<input type="checkbox"/> Wears glasses	<input type="checkbox"/> Other
<input type="checkbox"/> Deafness	<input type="checkbox"/> Kidney/Bladder	<input type="checkbox"/> Mild <input type="checkbox"/> Severe	<input type="checkbox"/> Convulsive seizure
Medical/Dietary Concerns:			
Please provide all information requested.			
Parent Carrying Insurance		Clinic Name	
Employed By		Clinic Phone #	
Health Insurance Company		Physician Name	
Group #		Preferred Hospital	
ID #		Hospital Address	
Dentist Name		Clinic Phone #	