

STUDENT EMERGENCY CONTACT FORM

In the event of an accident or medical emergency, do you give permission to transport your child to the nearest medical facility? Yes No

DETAILS

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone: _____

Email: _____

EMERGENCY CONTACTS

Please list the details of two people to be contacted in the event of an emergency.

Primary Emergency Contact

Name: _____

Home Address: _____

Relationship: _____

Home Phone Number: _____ Cell Phone: _____

Secondary Emergency Contact

Name: _____

Home Address: _____

Relationship: _____

Home Phone Number: _____ Cell Phone: _____

MEDICAL CONTACTS

Please provide details of the physician or health care provider that you would like us to contact in the event of an emergency:

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone: _____