Emergency Contact and Medical Information for Student

Student's Name _____ Date of Birth _____ M F Sex

Parent's/Guardian's Name _____ Parent's/Guardian's Name _____

Home Phone _____ Work Phone _____ Home Phone _____ Work Phone _____

Address _____ Address _____

City, St, Zip Code _____ City, St, Zip Code _____

Alternative Emergency Contacts

Primary Emergency Contact _____ Secondary Emergency Contact _____

Home Phone _____ Work Phone _____ Home Phone _____ Work Phone _____

Address _____ Address _____

City, St, Zip Code _____ City, St, Zip Code _____

Medical Information

Hospital Clinic Preference _____

Physician's Name _____ Phone Number _____

Insurance Company _____ Policy Number _____

Allergies/Special Health Considerations _____

I, _____, hereby authorize Spring of Life Academy to seek medical treatment for my child, _____], in the event of an emergency where I cannot be reached. I understand that every effort will be made to contact me or the designated emergency contacts listed below before any medical treatment is administered.

Parent's/Guardian's Signature _____ Date _____