FLINT COMMUNITY SCHOOL STUDENT EMERGENCY CARD

Room #_____

Student's name _____ Age _____
LAST NAME FIRST NAME MI

Grade _____ Date of Birth _____/_____/_____ Gender _____ Teacher _____

Home Address_____ City _____ Zip _____

Home Phone (____) _____ Cell Phone (___) _____ Other (____) _____

E-mail Address: _____

Student Lives With: _____ Both Parents _____ Mother _____ Father _____ Legal Guardian (Please Specify):
_____ Step Mother _____ Step Father _____ Other Relative _____ Non-Relative

PARENT(S)/GUARDIAN(S) NAMES

_____ _____ _____ _____
Father's or Legal Guardian's Name Home Phone Work Phone Cell Phone

_____ _____ _____ _____
Mother's or Legal Guardian's Name Home Phone Work Phone Cell Phone

EMERGENCY CONTACTS
Please list the emergency contact persons if the parent/guardian cannot be reached. *(Note: Only those persons listed will be permitted to pick up your child unless prior arrangements have been made with the school attendant.)*

1. Name _____ Relationship_____ Phone _____

2. Name _____ Relationship_____ Phone _____

3. Name _____ Relationship_____ Phone _____

Siblings: _____ School: _____ Grade _____

_____ School: _____ Grade _____

_____ School: _____ Grade _____

HEALTH HISTORY *(Check all that pertain to your child)*

Allergies (Specify) - _____

_____

Medications (Specify) _____

Medical Conditions - □ Asthma □ Diabetes □ Hearing Loss □ Seizures □ Other (Specify) _____
□ Physical Restrictions (Specify) _____ □ Special Needs (Specify) _____

Will the school be responsible for administering medication to your child? _____ YES _____ NO
Request to Medicate Student is on file at school. _____YES _____ NO

Will your child be responsible to self administer emergency medication? _____ YES _____ NO
Request to Self Medicate is on file at school. _____YES _____ NO

EMERGENCY RELEASE
In case of accident or serious illness, I give permission for the school to contact 911. If 911 is contacted, I request the school to contact me. My signature below empowers the school to make whatever arrangements deemed necessary and I will accept financial responsibility.

Physician's Name _____ Phone Number _____

Preferred Hospital _____

Signature of Parent/Guardian _____ Date _____