

VILLAGE GATE CHILDREN'S ACADEMY PUPIL EMERGENCY INFORMATION CARD

STUDENTS LEGAL NAME _____
LAST FIRST MIDDLE

BIRTHDATE ___/___/___ BIRTHPLACE _____ GRADE _____

ADDRESS _____ CITY _____ ZIP CODE _____

HOME PHONE # _____ CELL PHONE # _____

EMAIL _____

NAME OF MOTHER _____ NAME OF FATHER _____

Lives at residence address with child? (circle) Yes No Deceased

Lives at residence address with child? (circle) Yes No Deceased

ALTERNATE ADDRESS _____

ALTERNATE ADDRESS _____

WORK NUMBER _____

WORK NUMBER _____

ADDITIONAL PHONE NUMBER _____

ADDITIONAL PHONE NUMBER _____

EMPLOYER/OCCUPATION _____

EMPLOYER/OCCUPATION _____

SIBLINGS AND BIRTHDATES _____

OTHER PERSONS AUTHORIZED TO PICK UP MY CHILD IN AN EMERGENCY (MUST BE AT LEAST 18 YEARS OF AGE)

1. _____

2. _____

3. _____

4. _____

Name(s) of person(s) authorized by current COURT ORDER (on file at school office) who DO NOT have access to pupil: _____

STUDENT HEALTH INFORMATION

PHYSICIAN NAME _____ PHONE NUMBER _____

ADDRESS _____ CITY _____ ZIP CODE _____

DENTIST NAME _____ PHONE NUMBER _____

ADDRESS _____ CITY _____ ZIP CODE _____

If your child is seriously ill or injured and you cannot be contact, the paramedics will be called and your child will be transported by ambulance to the hospital.

This pupil's doctor, hospital, or dentist may give emergency treatment (circle) Yes No

INSURANCE PROVIDER _____

PHONE NUMBER _____

GROUP/PLAN NUMBER(s) _____

HEALTH PROBLEMS: (Please check all areas concerning your child's current health)

_____ Allergies – please specify _____

_____ Diabetes – since age _____

_____ Asthma – please circle Mild Moderate Severe

_____ Seizure disorder – please describe _____

_____ Heart Problems – please describe _____

_____ Urinary tract problems – please describe _____

_____ Physical Education limits – please specify _____

_____ Other – please specify _____

_____ Wears glasses for _____ Exam Date _____

_____ Hearing problems _____ Exam Date _____

Is student on any medication please circle Yes No

If yes, name of medication/Frequency _____

OTHER INFORMATION

HEALTH PROBLEMS: Above health problems may be shared with appropriate school staff. Please circle Yes No

SCHOOL DIRECTORY: I give permission to put our information in the school directory. Please circle Yes No

Parent/Guardian signature indicates agreement with above statements and that all information has been read.

PARENT/GUARDIAN SIGNATURE _____

DATE _____