# *Accelerated Elementary and Secondary Schools*

## Emergency Contact Information

**Please notify the school any time this information changes.**

| Student's Last Name | Student's First Name | D O B |
|---|---|---|
| Street Address | City, State, ZIP | Grade<br><br>Teacher |

In case of emergency, we will contact persons in the order you designate below to care for your child. A rescue squad may be called in a life-threatening situation.

| **Name** | **Relationship** | **Phone** | **Phone** | **Phone** |
|---|---|---|---|---|
| | Mother | | | |
| | Father | | | |
| | | | | |
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**List any allergies, their reactions, and the desired treatment below**.

| **Allergen** | **Reaction** | **Treatment** | **Date of Last Occurrence** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

| Primary Physician's Name, Address, Phone Number | Health Insurance Company | Name of Health Insurance Policy Holder |
|---|---|---|
| | | |

☐ I give permission to school personnel to administer over-the-counter medications (such as cough drop, pain reliever, antacid) to my child.

☐ **I DO NOT** give permission to administer any over-the counter medication to my child without my verbal permission on a per-incident basis.

In case of serious illness or injury, I give permission for my child to be taken to our doctor's office or closest hospital by school personnel or ambulance, and emergency care provided there until I can be contacted. By signing below, I affirm that I am the person responsible and able to make these decisions for this child.

| Printed Name | Signature | Date |
|---|---|---|
| | | |