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 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			

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