

## **IMPORTANT PHONE NUMBERS**

## **EMERGENCY CALL 911**

ADDRESS:  PHONE:( ) - PHONE:( ) -  DENTIST: HOSPITAL:  ADDRESS: ADDRESS:  PHONE:( ) - PHONE:( ) -  FATHER: EMPLOYER EMPLOYER NAME: EMPLOYER ADDRESS:  MOBILE:( ) - OFFICE PHONE:( ) - EMAIL ADDRESS:  ALTERNATE CONTACT ALTERNATE CONTACT NAME: PHONE:( ) -  EMAIL ADDRESS: PHONE:( ) -  EMAIL ADDRESS: ELATIONSHIP:  PHONE:( ) -  RELATIONSHIP: RELATIONSHIP:  SCHOOL NAME: EMERGENCY/EVACUATON MEET UP INSTRUCTIONS:	PEDIATRICIAN:	POISON CONTROL CENTER:
DENTIST:  ADDRESS:  ADDRESS:  PHONE:( ) -  PHONE:( ) -  FATHER:  EMPLOYER  NAME:  EMPLOYER  ADDRESS:  MOBILE:( ) -  OFFICE PHONE:( ) -  EMAIL ADDRESS:  ALTERNATE CONTACT  NAME:  PHONE:( ) -  RELATIONSHIP:  GRADE/TEACHER NAME:  SICK LINE:( ) -  SICK LINE:( ) -  PHONE:( ) -  REMOSPITAL:  ADDRESS:  MOTHER:  EMPLOYER  NAME:  EMPLOYER  ADDRESS:  MOBILE:( ) -  OFFICE PHONE:( ) -  EMAIL ADDRESS:  ALTERNATE CONTACT  NAME:  PHONE:( ) -  RELATIONSHIP:  SCHOOL NAME:  INSTRUCTIONS:	ADDRESS:	
ADDRESS:  ADDRESS:  PHONE:( ) -  FATHER:  EMPLOYER  NAME:  EMPLOYER  ADDRESS:  MOBILE:( ) -  OFFICE PHONE:( ) -  EMAIL ADDRESS:   ALTERNATE CONTACT  NAME:  PHONE:( ) -  RELATIONSHIP:  SCHOOL NAME:  SICK LINE:( ) -  SICK LINE:( ) -  PHONE:( ) -  RELATIONS:  ADDRESS:  MOTHER:  EMPLOYER  NAME:  EMPLOYER  NAME:  EMPLOYER  NAME:  EMPLOYER  NAME:  EMPLOYER  ADDRESS:  MOBILE:( ) -  OFFICE PHONE:( ) -  EMAIL ADDRESS:  ALTERNATE CONTACT  NAME:  PHONE:( ) -  RELATIONSHIP:  EMERGENCY/EVACUATON MEET UP  INSTRUCTIONS:	PHONE: ( ) -	PHONE: ( ) -
PHONE:( ) - PHONE:( ) -  FATHER:  EMPLOYER  NAME:  EMPLOYER  ADDRESS:  MOBILE:( ) -  OFFICE PHONE:( ) -  EMAIL ADDRESS:  ALTERNATE CONTACT  NAME:  PHONE:( ) -  RELATIONSHIP:  SCHOOL NAME:  SICK LINE:( ) -  SICK LINE:( ) -	DENTIST:	HOSPITAL:
FATHER: EMPLOYER NAME: EMPLOYER ADDRESS:  MOBILE: ( ) - OFFICE PHONE: ( ) - EMAIL ADDRESS:   ALTERNATE CONTACT NAME: PHONE: ( ) - RELATIONSHIP:  SCHOOL NAME: GRADE/TEACHER NAME:  MOTHER: EMPLOYER NAME: EMPLOYER ADDRESS:  MOBILE: ( ) - OFFICE PHONE: ( ) - EMAIL ADDRESS:  ALTERNATE CONTACT NAME: PHONE: ( ) - RELATIONSHIP:  EMERGENCY/EVACUATON MEET UP INSTRUCTIONS:	ADDRESS:	ADDRESS:
EMPLOYER NAME: EMPLOYER ADDRESS:  MOBILE: ( ) - OFFICE PHONE: ( ) - EMAIL ADDRESS:  ALTERNATE CONTACT NAME: PHONE: ( ) - RELATIONSHIP:  SCHOOL NAME: GRADE/TEACHER NAME:  SICK LINE: ( ) -  EMPLOYER NAME: EMPLOYER NAME	PHONE: ( ) -	PHONE: ( ) -
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EMAIL ADDRESS:  ALTERNATE CONTACT NAME: PHONE: ( ) - RELATIONSHIP: SCHOOL NAME: GRADE/TEACHER NAME:  SICK LINE: ( ) -		
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NAME:  PHONE: ( ) -  RELATIONSHIP:  SCHOOL NAME:  GRADE/TEACHER NAME:  SICK LINE: ( ) -		
PHONE: ( ) -  RELATIONSHIP:  SCHOOL NAME:  GRADE/TEACHER NAME:  SICK LINE: ( ) -	ALTERNATE CONTACT	ALTERNATE CONTACT
RELATIONSHIP:  SCHOOL NAME: GRADE/TEACHER NAME:  SICK LINE: ( ) -	NAME:	NAME:
SCHOOL NAME:  GRADE/TEACHER NAME:  SICK LINE: ( ) -	PHONE: ( ) -	PHONE: ( ) -
GRADE/TEACHER NAME:  SICK LINE: ( ) -	RELATIONSHIP:	RELATIONSHIP:
SICK LINE: ( ) -	SCHOOL NAME:	EMERGENCY/EVACUATON MEET UP
	GRADE/TEACHER NAME:	INSTRUCTIONS:
MAIN LINE: ( ) -	SICK LINE: ( ) -	
	MAIN LINE: ( ) -	

In an emergency, when all phone circuits are busy, text messaging may still be operable.



## IMPORTANT PHONE NUMBERS

## **EMERGENCY CALL 911**

CHILD'S PERSO	NAL INFORMATION	
Name:	Date of Birth:	
Sex:	Social Security #:	
Hair:	Eyes:	
Allergies:		
Medical Conditions/Medication:		
CHILD'S PERSONAL INFORMATION		
Name:	Date of Birth:	
Sex:	Social Security #:	
Hair:	Eyes:	
Allergies:	Lyes.	
Allei gles.		
Medical Conditions/Medication:		
·		
MEDICAL INSURANCE INFORMATION		
Name of Insured:	Employer:	
Ins. Company:		
Member No.:		
Insured/Employee ID:		
Group #:	Confirmation Phone No.: ( ) -	
PARENTAL AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT:		
In the case of accident or illness, should my child(ren		
the time that s/he is in the care of		
accident of any character, I (we) shall be contacted immediately. In the event that I (we) cannot be contacted		
immediately, the above named caregiver shall be authorized to secure such medical attention and care as		
may be necessary from duly licensed medical and dental personnel.		
Parant Cignatura	Data	
Parent Signature:	Date:	
PLEASE ATTACH A COPY OF INSURANCE AND PRESCRIPTION PLAN IDENTIFICATION CARDS		
AUTOMOBILE INSURANCE INFORMATON		
Ins. Company:	Policy ID:	
PHONE: ( ) -		