BOYLE COUNTY SCHOOLS

EMERGENCY INFORMATION FORM

Student's Name: _____
Last Name *First Name* *Middle Initial*

Student's Address: _____
Street Address/Apt. # *City* *State* *Zip Code*

Student's Age: _____ Date of Birth: _____ Student's Phone Number _____

Grade: _____ Teacher (Homeroom)/Classroom: _____ Bus #: _____

TO BE COMPLETED BY PARENT/GUARDIAN

To serve your child in case of accident or sudden illness, it is necessary that you furnish the following information:

Mother's Name: _____
Last Name *First Name* *Middle Initial*

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____

Father's Name: _____
Last Name *First Name* *Middle Initial*

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____

Other Name: _____
Last Name *First Name* *Middle Initial*

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____

Student's Insurance Carrier: _____ Policy Number: _____

Family Doctor's Name: _____ Phone Number: _____

Address: _____

In case of emergency, accident, or serious illness of the above named student, I request and authorize Boyle County Schools to take action necessary to maintain the student's health. If school personnel are unable to contact me, I hereby authorize them to release my students health information to emergency/hospital personnel and anyone authorized to pick up my child from school or school sponsored activity.

Parent/Guardian Signature: _____ Date: _____

Is your child on any daily medication? ☐ No ☐ Yes If yes, please list below:

MEDICATION	DOSAGE

Is your child allergic to medication(s)? ☐ No ☐ Yes If yes, please specify: _____

_____

Is your child allergic to insect bites? ☐ No ☐ Yes If yes, please specify: _____

_____

Does your child have food allergies? ☐ No ☐ Yes If yes, please specify: _____

_____

Does your child have a history of: (check appropriate boxes)

☐ Heart Disease ☐ Diabetes ☐ Seizure ☐ Asthma ☐ Other: (please specify)

_____

If so, please describe any special emergency treatment that may be required: _____

_____

Please list any health conditions that might require emergency medical treatment: _____

_____

Parent/Guardian Signature: _____ Date: _____

Log of Attempts to Contact Parent/Guardian

Date	Time	Phone Number Called	Answered?		Person Answering Phone/Response
			Yes	No	

To Be Completed If Student Is Transported

Date of Transportation: _____ Time of Transportation: _____ ☐ AM ☐ PM

Destination: _____ Arrival Time: _____ ☐ AM ☐ PM

Means of Transportation: (check appropriate box)

☐ EMS Vehicle ☐ Board-Owned Vehicle ☐ Private Vehicle

If Board-owned vehicle or private vehicle, list name of driver: _____

Driver is the/a: (check appropriate box)

☐ Parent/Guardian ☐ School Administrator ☐ Teacher ☐ Other Board Employee ☐ Relative (specify) _____