

Student's Name: _____ Grade: _____

Student Emergency Card
Lake Orion Baptist School
School Year: _____

Student's Name: _____			
Date of Birth: _____		Home Phone: _____	
Student's Home Address: _____ _____			
Father: _____			
Place of Employment: _____			
Work Phone: _____		Cell Phone: _____	
Email: _____			
Mother: _____			
Place of Employment: _____			
Work Phone: _____		Cell Phone: _____	
Email: _____			
Siblings:	Name	Birth Date	Grade
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Parent Living Elsewhere: _____			
Relationship to Child: _____			
Address: _____			
Home Phone: _____		Work Phone: _____	
Cell Phone: _____		Email: _____	

Please list below local contacts in the order to be called in case of illness/emergency so student can be released:

1. Emergency Contact Person: _____ Relationship: _____
Phone: _____ Cell: _____
2. Emergency Contact Person: _____ Relationship: _____
Phone: _____ Cell: _____
3. Emergency Contact Person: _____ Relationship: _____
Phone: _____ Cell: _____
4. DOCTOR: _____ Phone: _____
Hospital of choice: _____ Phone: _____
Medical Insurance Info, Company & Plan #: _____

5. DENTIST: _____ Phone: _____

Dental Insurance Info, Company and Plan #: _____

Medical Conditions/Problems: check **ALL** that apply

- | | | |
|---|---|---|
| <input type="checkbox"/> nothing known | <input type="checkbox"/> asthma | <input type="checkbox"/> bee sting allergy |
| <input type="checkbox"/> cardiac | <input type="checkbox"/> peanut allergy | <input type="checkbox"/> hemophiliac |
| <input type="checkbox"/> diabetic | <input type="checkbox"/> aspirin allergy | <input type="checkbox"/> nose bleeds |
| <input type="checkbox"/> headaches | <input type="checkbox"/> penicillin allergy | <input type="checkbox"/> wears glasses |
| <input type="checkbox"/> contact lenses | <input type="checkbox"/> iodine allergy | <input type="checkbox"/> hearing problems |
| <input type="checkbox"/> latex allergy | <input type="checkbox"/> sulpham allergy | <input type="checkbox"/> epileptic/seizure disorder |
| <input type="checkbox"/> other allergies: _____ | | |
| <input type="checkbox"/> takes medication regularly (please indicate which medication, for treatment of what disorder, and how often) _____ | | |

Does your child require medication (including non-prescription) during school hours? Yes No
If yes, an "Authorization to Administer Medication" form must be completed and signed by the parent.
Forms can be obtained from the school office.

Does your child have any physical restrictions? Yes No
If yes, please explain: _____

Are there any before/after school arrangements which we should be aware of? Yes No

If yes, please explain: _____

Please list the names of people your student may carpool with:

In an emergency, the information on this card could be imperative to the welfare of your child; thus we ask that you carefully fill it out and promptly return it to the school. Also, PLEASE KEEP THE SCHOOL INFORMED OF ANY CHANGES THAT MAY OCCUR DURING THE COURSE OF THE SCHOOL YEAR REGARDING ADDRESS AND PHONE NUMBERS. This information is also important in the event that the school must be dismissed early due to weather conditions or mechanical failure in our building. Your child should know what to do in these situations. Please inform your child of the procedure he/she is to follow when no one is at home in the event of early school dismissal.

I authorize the physician and/or hospital listed on this document to treat my child in the event of serious illness or accident, when I or the other persons listed on this card cannot be reached. Any obligation for medical expenses resulting from treatment in such a case is my responsibility. Permission to transport my child in case of emergency is also given.

Father Signature: _____ Date: _____

Mother Signature: _____ Date: _____