



EMERGENCY CARE INFORMATION FORM

In case of emergency, the school staff will contact 911.
 Every attempt will be made to contact a parent/guardian or emergency contact.

Fill in all blanks. If any field below does not apply, mark "N/A" in that field.

SECTION 1: CONTACT INFORMATION

STUDENT INFORMATION		Teacher (to be completed by school):
Last Name:	Nickname:	Class:
First Name:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F	Language Spoken at Home:
Middle Name:	Date of Birth:	Email to be used for school purposes:
Student resides with (Check all that apply): <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Legal Guardian		
MOTHER/FATHER/LEGAL GUARDIAN (circle one)		Telephone
Last Name:	Home Address:	Home:
First Name:		Work:
Middle Name:		Cell:
Employer:	Work Address:	
MOTHER/FATHER/LEGAL GUARDIAN (circle one)		Telephone
Last Name:	Home Address (if different from above):	Home:
First Name:		Work:
Middle Name:		Cell:
Employer:	Work Address:	

SECTION 2: HEALTH INFORMATION

If your child has ANY allergies (food, medication, environmental), special dietary needs, medical conditions (such as asthma), physical, or an emotional condition that may require attention during the school day, please specify the condition and action to be taken below. Additional forms (such as emergency medication authorization form) or documentation (such as emergency action plan) may be required.

**** Do NOT leave this section blank. If there are no allergies, dietary needs, or conditions please write "N/A". ****

Allergy or Condition	Reaction (such as wheezing)	Action to be taken (such as give Epi-pen, call parent)

SECTION 3: PHYSICIAN INFORMATION

Child's Physician:		Telephone:
Insurance Company:	Member ID:	Group #:

SECTION 4: EMERGENCY CONTACT INFORMATION

List two (2) persons ACPS should call in an emergency if the parent(s)/guardian cannot be reached. These people also have your permission to pick your child up from school during the school day. Emergency contacts must be **within 30 minutes** of ACPS between the hours of 9:00 AM and 1:15PM on school days.

Name of Person	Relationship	Telephone	Address
1. _____			
2. _____			

List ALL persons (in addition to parents and emergency contacts) that are AUTHORIZED TO PICK-UP CHILD. *This information will be included in the teacher's Authorized Pick-Up List.*

List all persons NOT AUTHORIZED TO PICK-UP child. *Appropriate paperwork such as divorce decree to be attached if a parent is not authorized to pick-up child.*

SECTION 5: PERMISSIONS

Please initial each of the following:

_____ ACPS has my permission, in an emergency when I cannot be reached, to take my child to the emergency room of the nearest hospital. The hospital and its medical staff have my authorization to provide treatment which a physician deems medically necessary for the well-being of my child. I understand that I am responsible for medical expenses incurred.

_____ I give authorization for my child to participate in the preschool's field trips.

_____ I give permission for my child's food allergies and/or other medical conditions to be posted in the classroom,.

Parent/Guardian Signature: _____ **Date:** _____