

Robertson County School

Emergency Information Form / 2021 – 2022 School Year

Student's Name _____	_____	_____	_____
	<i>Last Name</i>	<i>First Name</i>	<i>Middle Initial</i>
Student's Address _____	_____	_____	_____
	<i>Street Address/Apt. #</i>	<i>City</i>	<i>State Zip Code</i>
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

Mother's Employer _____ Phone # _____

FATHER'S NAME _____
Last Name
First Name
Middle Initial

Father's Employer _____ Phone # _____

GUARDIAN'S NAME _____
Last Name
First Name
Middle Initial

Guardian's Employer _____ Phone # _____

In case of emergency, accident, or serious illness of the above named child, I request the school to contact me. If school personnel are unable to contact me, I hereby authorize them to call the following people who are authorized to pick up my child from school or a school-sponsored activity:

<i>Name</i>	<i>Phone Number</i>	<i>Relationship</i>
_____	_____	_____
_____	_____	_____

Doctor's Name: _____ Phone # _____

Address: _____

If it is impossible to contact the physician named above, I hereby authorize the school to take action necessary to maintain the student's health.

Signature of Parent/Guardian
Date

Emergency Information Form

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

Medication	Dosage

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

Is your child allergic to insect bites? Yes No

Does your child have allergies? Yes No

Does your child have a history of heart disease diabetes T.B nervous disorder
 epilepsy ear infection seizure asthma Other _____?

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

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

Signature of Parent/Guardian

Date

Log of Attempts to Contact Parent/Guardian

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

Review/Revised:4/21/14