



Emergency / Health Information Form

VERY IMPORTANT --- Please **CIRCLE** any information that is new or changed since last school year.

Student's Full Name: _____ School Year: _____
First Middle Last

Birth Date: ____/____/____ Is Student new to this school this year? _____ Grade: _____

MOTHER/GUARDIAN'S INFORMATION

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail: _____

FATHER/GUARDIAN'S INFORMATION

Name: _____

Address: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

E-mail: _____

Mother's place of employment: _____

Father's place of employment: _____

Student lives with (*circle one*): **Both Parents** **Mother** **Father** **Other:** _____

Please list two alternate persons you authorize to pick up your child at school in case of accident/illness.

Name: _____ Phone number(s): _____/_____

Name: _____ Phone number(s): _____/_____

In the event of a serious injury or illness, when the parent cannot be contacted, an ambulance will be called to take your child to the emergency room.

Doctor or Healthcare facility preference: _____

Has student had a routine physical exam/check up in the past 24 months? (*Circle one*) **YES** **NO**

Dentist or Dental facility preference: _____

Has student had routine dental exam/check-up in past 12 months? (*Circle one*) **YES** **NO**

Insurance (*circle one*): **Private or Employer provided** **Medicaid/MC+/Missouri Health Care for Children** **None**