

Emergency Care Card

Grade _____ Teacher _____

Bus# _____ Age _____

Student's Name _____ Date of Birth _____
Last First MiddlePhysical Address: _____
Street City ZipMailing Address: _____
P.O. Box City Zip

Home Phone: _____ Cell Phone: _____

Parent/Guardian _____ Employer _____ Phone# _____

Parent/Guardian _____ Employer _____ Phone# _____

List (2) neighbors or relatives who will assume temporary care of your child(ren) if you cannot be reached:

Name _____ Relationship _____ Address _____ Phone _____

Name _____ Relationship _____ Address _____ Phone _____

OVER

Rev. 5/08

- M - Do not release Directory Info. to Military Recruiters (SR & JR only)
 D - Do not release Directory Information to ACPS Directory
 N - Do not release Directory Information to any of the above
 Y - OK to release Directory Information

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Family Physician _____ Phone# _____ Dentist _____

Medications given at home (on a regular basis) _____

Please check any existing health conditions: ADD/ADHD **Allergies (explain)** _____ Asthma Uses Inhalers Uses Nebulizer Bleeding Problem Diabetes Fainting Spells Hearing Problems Heart Problems Headaches/Migraines Seizures Speech Problems Vision Problems Other Problems _____

 Bee Sting Allergy Swelling or redness Difficulty Breathing Swelling of lips& eyes Hives

Describe your child's reaction: _____

Uses an EpiPen: Yes No**Please list all brothers & sisters living in the home:**

Name _____ Birth Date _____ School _____

Name _____ Birth Date _____ School _____

Name _____ Birth Date _____ School _____

Name _____ Birth Date _____ School _____

I give permission for my child's health information to be shared with appropriate school staff. Yes _____ No _____

PARENT/GUARDIAN SIGNATURE _____ DATE _____