EMERGENCY INFORMATION

OLM HEALTH OFFICE

Please use black ink

ALLERGY:

GRADE ________ **TEACHER** ___________________________

STUDENT'S NAME ________________________________ **BIRTHDATE** __________
Last/First

ADDRESS ____ **PHONE** ________________

MOTHER'S NAME ____

FATHER'S NAME ____

LIVES WITH: Both parents ___ Mother only ___ Father only ___ Other ____

PARENTS'/GUARDIANS' CONTACT NIUMBERS:

Mother: (H) ________________ (W) __________________ (C) __________________

Father: (H) ________________ (W) __________________ (C) __________________

IF PARENT CANNOT BE REACHED, PLEASE CALL: (list only people nearby)

NAME/PHONE ______________________ **NAME/PHONE** ______________________

NAME/PHONE ______________________ **NAME/PHONE** ______________________

DOCTOR/PHONE ___________________ **DENTIST/PHONE** ____________________

IN THE EVENT OF A SERIOUS MEDICAL EMERGENCY OR ACCIDENT, IF I AM NOT AVAILABLE, I AUTHORIZE SCHOOL PERSONNEL TO HAVE MY CHILD TREATED BY A READILYAVAILABLE PHYSICIAN AND/OR HOSPITAL

____ ___________________
Signature of Parent/Guardian Date

PLEASE NOTIFY SCHOOL PROMPTLY OF ANY CHANGES IN ABOVE INFORMATION