VISIONS UNLIMITED **2021-22 SCHOOL YEAR**
STUDENT EMERGENCY INFORMATION

Birthdate:______________________

Student Name:____ Home Phone:______________________________

Address:____
(street) (city) (zip)

Please indicate the FIRST telephone number we should call in the event of an emergency:

__________________________________ ____
Telephone Number Contact Name

Please list the student's parents, stepparents, guardians that child lives with. State relationship where applicable (i.e., father, stepmother, guardian*). *Guardianship papers must be on file in office.

Student Lives With:

1.____
Last Name First Relationship Place of Employment Day/Cell

2.____
Last Name First Relationship Place of Employment Day/Cell

Non-custodial parent information

Parent____
Last Name First Number/Street City/Zip Day/Cell

Step-parent____
Last Name First Number/Street City/Zip Day/Cell

Neighbors or relatives school may contact in case of emergency if parent/guardian cannot be reached:

____
Name Relationship Day/Cell

____
Name Relationship Day/Cell

HOSPITAL OF CHOICE (IN CASE OF EMERGENCY): ______________________________________
In case of serious illness or accident, if the school is unable to contact me, I hereby authorize the school authorities to use their best judgment on behalf of my child.

PLEASE FILL OUT BACK OF THIS FORM

Health Information

Particular health problems: e.g., Heart, Kidney, Orthopedic, etc. No_____ Yes_____ (Please specify) ________________________

____

Does student have seizures? No_____ Yes_____ (If yes, describe likely pattern) ____

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Does student have allergies: If yes, please indicate below:

Medicine:____
Foods:____
Insects:____
Pollen:____
Others:____

List all medications taken BOTH AT SCHOOL AND HOME

Name of Medicine:______________________ Dosage:__________________Time Administered:___________

Name of Medicine:______________________ Dosage:__________________Time Administered:___________

Name of Medicine:______________________ Dosage:__________________Time Administered:___________

Attach a list of additional medications, if necessary, including dosage and time administered.

Date of last physical examination:____________________

Physician's Name:_________________________________Phone:_________________________________

Dentist's Name:___________________________________Phone:_________________________________

DATE OF ALL IMMUNIZATIONS *(If you submitted these records to Visions in the past, no need to send them in again.*

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Parent/Guardian Signature:_________________________________Date:____________________________