EMERGENCY CONTACT INFORMATION FORM

THIS INFORMATION WILL BE EXTREMELY IMPORTANT IN THE EVENT OF AN ACCIDENT OR MEDICAL EMERGENCY.
PLEASE BE SURE TO SIGN AND DATE THIS FORM

Name: _____ **DOB:** _____

Personal Contact Information:

Home Address: _____

Mailing Address: _____

City, State, ZIP: _____

Home Telephone # _____ **Cell #** _____ **Carrier:** _____
(Please provide your cell phone carrier for text notifications)

Personal Email: _____

Primary Emergency Contact:

Name: _____ **Relationship:** _____

Address: _____

City, State, ZIP: _____

Home Telephone # _____ **Cell #** _____

Secondary Emergency Contact:

Name: _____ **Relationship:** _____

Address: _____

City, State, ZIP: _____

Home Telephone # _____ **Cell #** _____

I authorize the following to perform any emergency treatment as needed:

Physician: _____ **Phone:** _____

Address: _____

City, State, ZIP: _____

Or

Physician: _____ **Phone:** _____

Address: _____

City, State, ZIP: _____

In the event that the above-named persons cannot be contacted, I authorize the school to act on my behalf. Please write any special information that should be known in case of an emergency, example: allergies, diabetic, epileptic, seizures, religious beliefs, special accommodations, etc.

_____

_____

Date: _____ Signature: _____

******OFFICE USE ONLY: __Aeries __AESD-1/STRS __AESOP __CVT __ESCAPE __Safe Schools __SISC******