

Student Information/Emergency Sheet

Student Name: \_\_\_\_\_ DOB \_\_\_\_\_

Parents: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Do you check your email frequently? \_\_\_\_\_

Emergency Contacts: (List name and phone numbers.)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

Does your child have any allergies or chronic medical problems that we need to know about? If so, please explain.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there any medication that your child needs on a regular basis?

\_\_\_\_\_

Name of doctor: \_\_\_\_\_ Phone number: \_\_\_\_\_

Other information that we need to know about your child: \_\_\_\_\_

\_\_\_\_\_