



Medical Information:

Does your child wear glasses? \_\_\_\_ Yes \_\_\_\_ No    Does your child wear contacts? \_\_\_\_ Yes \_\_\_\_ No

Other Medical Info we should know, (Allergies, Injuries, surgeries, etc.) \_\_\_\_\_

Daily Medications being taken \_\_\_\_\_

(\* A medication release form must be on file in the school office in order to receive medication at school. This includes both prescription and non-prescription medication.)

Student's Doctor \_\_\_\_\_ Phone# \_\_\_\_\_

Doctor's Address \_\_\_\_\_

**\*\*Please list at least two emergency contact people other than parents.\*\***

#1 Emergency Contact Person's Name \_\_\_\_\_

Relationship to Student \_\_\_\_\_

Emergency Person's Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

#2 Emergency Contact Person's Name \_\_\_\_\_

Relationship to Student \_\_\_\_\_

Emergency Person's Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

#3 Emergency Contact Person's Name \_\_\_\_\_

Relationship to Student \_\_\_\_\_

Emergency Person's Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_