Eagle View Christian School
Emergency Information

Student Name: _____ _____ _____ _____
(Last) (First) (Grade) (Date of Birth)

Parent/Guardian's Name: _____

Home Address: _____ Home Phone: _____

_____ _____ _____ E-Mail: _____
City State Zip

Father's Business Address: _____ Business Phone: _____

_____ _____ _____ Cell Phone: _____
City State Zip

Mother's Business Address: _____ Business Phone: _____

_____ _____ _____ Cell Phone: _____
City State Zip

Alternate persons to be notified in case of emergency or authorized persons to pick up your child from school:

Name	Relationship	Phone

If Parent/Guardian named above cannot be reached in the time of an emergency, and if the immediate observation or treatment is urgent in judgment of the school staff, do you authorize and direct the school staff to accompany the student to the hospital or doctor most accessible? ☐ YES ☐ NO

Do you agree to be financially responsible for all expenses incurred for treatment under the circumstances above? ☐ YES ☐ NO

If an ambulance responds, do you accept full responsibility for expenses incurred? ☐ YES ☐ NO

IF the answer to any of the above questions is NO, please explain what action you desire the school staff to take on behalf of your child:

Allergies: Plants: ☐ Foods: ☐ Bees or other insects: ☐ Animal: ☐ Other: ☐ _____

Describe the reaction: _____

Is medication needed for allergy? ☐ YES ☐ NO

Does your child regularly take medication? ☐ YES ☐ NO If yes, please explain below:

Pertinent medical background information: _____

Does your child wear glasses? ☐ Yes ☐ No If so, For what purpose? _____

_____ _____
Parent/Guardian Signature Date