

Emergency Record
Independent School District 0832
Mahtomedi Public Schools

For Office Use Only:
Student ID: _____
Family ID: _____
Date Printed: 8/27/2010

Please check the information below, fill in what is missing and correct what is in error. Thank you.

Student: _____ **Home Phone:** () _____
Grade: ____ **Teacher:** _____ **Birth Date:** _____ **Gender:** ____ **Ethnicity:** _____
Home Address: _____ **AM Bus:** _____
City: _____ **State:** ____ **Zip:** _____ **PM Bus:** _____

Please use area code and identify phone number types: W=Work C=Cell P=Page

Parent or Guardian 1: _____ **Relationship to Student:** _____
Phone 1: () _____ **Phone 2:** () _____ **Phone 3:** () _____ **Child Lives With:**
E-mail: _____ **Place of Employment:** _____
Address, if different from above _____

Parent or Guardian 2: _____ **Relationship to Student:** _____
Phone 1: () _____ **Phone 2:** () _____ **Phone 3:** () _____ **Child Lives With:**
E-mail: _____ **Place of Employment:** _____
Address, if different from above _____

Brothers & Sisters: *(names, ages, and school(s) (if attending))* _____

Immunizations within the last year: *(Type and mo/day/yr)* _____

Current Health Problem(s): _____

Medications: _____

IN CASE OF AN EMERGENCY *(Two contacts who would care for this child in case a parent or guardian cannot be reached)*

Contact 1: _____ **Address:** _____
Phone 1: () _____ **Phone 2:** () _____ **Relationship to Student:** _____

Contact 2: _____ **Address:** _____
Phone 1: () _____ **Phone 2:** () _____ **Relationship to Student:** _____

Day Care Provider: _____ **Phone 1:** () _____

Family Doctor: _____ **Phone 1:** () _____

Family Dentist: _____ **Phone 1:** () _____

Hospital Preference: _____ **Phone 1:** () _____

Our procedure will be to contact the parent at home or at work. You will be asked to pick up the child and provide proper care. If we cannot reach you we will call the friend, relative, or neighbor that you have listed above and ask them to care for your child. In extreme emergency, an ambulance will be called and your child will be taken to the nearest hospital. The cost of this will be covered by the parent.

Parent or Guardian 1 Signature _____ **Date** _____

Parent or Guardian 2 Signature _____ **Date** _____