



**Emergency Identification & Contact Form 2017/2018**

**Student Full Name:**

**Date of Birth:**

**Age:**

**Contacts 1 & 2 are for Parent/Guardian. Contact 1, Phone #1 will be the first phone number used in the event of an emergency. Contact 3 is primarily meant for neighbors or family relatives.**  
**Please circle phone type for each number listed. You must fill in at least 2 contacts.**  
**K12 Alerts (Automatic Messaging): Please CIRCLE Yes next to each phone number or email address that you would like to receive Emergency Messages AND/OR Announcements**

**Contact 1 Parent/Guardian that Student Lives With**

Name:		Relationship:			<b>K12 Alerts Preferences</b>			
Address:					<b>EMERGENCY</b>		<b>Announcement</b>	
City/State/Zip:					<i>Voice</i>	<i>Text</i>	<i>Voice</i>	<i>Text</i>
Phone # 1:	Home	Cell	Work	Yes	Yes	Yes	Yes	
Phone # 2:	Home	Cell	Work	Yes	Yes	Yes	Yes	
Phone # 3:	Home	Cell	Work	Yes	Yes	Yes	Yes	
Email:					Yes		Yes	
<b>CIRCLE ALL</b> that apply for this contact:		<b>Lives With</b>	<b>Has Custody</b>	<b>Is Emergency</b>	<b>Can Pick Up</b>	<b>Mailings</b>		

**Contact 2 Parent/Guardian**

Name:		Relationship:			<b>K12 Alerts Preferences</b>			
Address:					<b>EMERGENCY</b>		<b>Announcement</b>	
City/State/Zip:					<i>Voice</i>	<i>Text</i>	<i>Voice</i>	<i>Text</i>
Phone # 1:	Home	Cell	Work	Yes	Yes	Yes	Yes	
Phone # 2:	Home	Cell	Work	Yes	Yes	Yes	Yes	
Phone # 3:	Home	Cell	Work	Yes	Yes	Yes	Yes	
Email:					Yes		Yes	
<b>CIRCLE ALL</b> that apply for this contact:		<b>Lives With</b>	<b>Has Custody</b>	<b>Is Emergency</b>	<b>Can Pick Up</b>	<b>Mailings</b>		

**Contact 3**

Name:		Relationship:				
Address/City/State/Zip:						
Phone # 1:	Home	Cell	Work			
Phone # 2:	Home	Cell	Work			
Phone # 3:	Home	Cell	Work			
<b>CIRCLE ALL</b> that apply for this contact:		<b>Lives With</b>	<b>Has Custody</b>	<b>Is Emergency</b>	<b>Can Pick Up</b>	<b>Mailings</b>

**Healthcare Provider Information**

**Insurance Provider:**

<b>Primary Care Physician:</b>	<b>Dentist:</b>
Office Phone:	Office Phone:
Address:	Address:
<b>Specialist:</b>	<b>Specialist:</b>
Specialist Type:	Specialist Type:
Office Phone:	Office Phone:
Address:	Address:

**Student Full Name:**

**Date of Birth:**

**Age:**

**Allergies**

List all known allergies & describe reaction and management of reaction

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**Important New and Updated Medical History/Information**

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**Please list any Dietary, Activity, or Other Limitations or Restrictions**

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**Current Medications**

Please list all medications (including over-the-counter or non prescription drugs) taken routinely

- This student takes NO medication on a routine basis
- This student takes medication as follows

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Parent/Guardian Signature

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Date