

EMERGENCY INFORMATION FORM  
CARDEN ARBOR VIEW SCHOOL

For school use only:  
\_\_\_ Finance  
\_\_\_ Registration  
\_\_\_ Development

Student's Names \_\_\_\_\_

Primary Address \_\_\_\_\_  home  mailing Home Phone \_\_\_\_\_

Secondary Address \_\_\_\_\_  home  mailing

PARENT(S) AND/OR GUARDIAN(S) LIVING AT THIS ADDRESS (please check appropriate relationship):

\_\_\_ Father \_\_\_ Step-father \_\_\_ Grandfather  
\_\_\_ Mother \_\_\_ Step-mother \_\_\_ Grandmother \_\_\_ Other

\_\_\_ Father \_\_\_ Step-father \_\_\_ Grandfather  
\_\_\_ Mother \_\_\_ Step-mother \_\_\_ Grandmother \_\_\_ Other

Name \_\_\_\_\_

Name \_\_\_\_\_

Company/Employer \_\_\_\_\_

Company/Employer \_\_\_\_\_

Occupation \_\_\_\_\_

Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_

Work Phone \_\_\_\_\_

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

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

Other Phone \_\_\_\_\_

Other Phone \_\_\_\_\_

E-mail \_\_\_\_\_

E-mail \_\_\_\_\_

CONTACTS IN THE EVENT PARENTS CANNOT BE REACHED:

Name	Phone	Relationship	Call in Case of Emergency	Authorized to Pick Up

Student's Physician \_\_\_\_\_ Physician's Phone \_\_\_\_\_

We will assume that physicians or Christian Science practitioners named above will continue to be your family physician or practitioner unless you notify us in writing to the contrary.

Known medical condition or disability requiring special emergency care \_\_\_\_\_

\_\_\_ Allergies \_\_\_ Asthma \_\_\_\_\_ Other

What medication, if any, does your child(ren) take regularly? \_\_\_\_\_

Medical Insurance Company \_\_\_\_\_ Policy/Group Number \_\_\_\_\_

- In emergency situations, I hereby authorize Carden Arbor View School staff to follow the procedure listed below:
1. Time and situation permitting, to make reasonable attempts to contact persons identified above.
  2. Time and situation permitting, to contact an ambulance service, medical doctor, or hospital as required.
  3. When persons identified above cannot be contacted, the office is hereby authorized to give consent for any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care under the supervision and upon advice of any licensed physician or surgeon.

Signature of parent or guardian \_\_\_\_\_ Relationship \_\_\_\_\_ Date \_\_\_\_\_

Comments: \_\_\_\_\_