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

Name ______________________
Company/Employer ______________________
Occupation ______________________
Work Phone ______________________
Cell Phone ______________________
Other Phone ______________________
E-mail ______________________

___ Father ___ Step-father ___ Grandfather
___ Mother ___ Step-mother ___ Grandmother ___ Other

Name ______________________
Company/Employer ______________________
Occupation ______________________
Work Phone ______________________
Cell Phone ______________________
Other Phone ______________________
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.

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Signature of parent or guardian Relationship Date

Comments: ______________________________