Do Not Fold/Pen Only

EMERGENCY HEALTH CARD

Student Last Name:_____ First Name:_____ D.O.B:_____

Address:_____ Phone:_____

Parent/Guardian:_____

Home #:_____ Cell #:_____ Work #:_____

Person to be Notified:_____ Phone # _____

Alternate Contact:_____ Phone #_____

Family Doctor:_____ Phone #_____

Please read the following and sign:

In case of an emergency, Mission CISD employees may use their judgement in sending my child to the hospital or doctor if a parent/guardian cannot be reached. Furthermore, I will not hold Mission CISD teachers, staff, agents, or trustees financially responsible for the emergency care and/or transportation for the said student.

In addition, I also give permission for my child to ride school transportation to all band functions throughout the year of 2015-2016 (July 31, 2015 – July 31, 2016).

I agree to this statement by signing this form.

Parent/Guardian Signature:_____ Date:_____

HEALTH HISTORY: (please circle/write any that apply)

Medical Problems

Diabetes

Epilepsy

Polio

Heart Condition

Rheumatic Fever

Other _____

Allergies

Food _____

Medications _____

Other_____

Childhood illnesses _____

Surgeries or Hospitalizations _____

Name of insurance: _____

Address: _____

Phone # _____ Policy # _____