

2024-2025 School Emergency Form

Student's Name: _____ Preferred Name: _____ Preferred Pronouns: _____

SSN: _____ Age: _____ DOB: _____

Home Address: _____ Home Phone: _____

Student's Cell Phone #: _____ Student Email: _____

Parent/Guardian #1 (Primary Contact): _____

Employer: _____ Work Phone #: _____

Cell Phone #: _____ Email: _____

Parent/Guardian #2: _____

Employer: _____ Work Phone #: _____

Cell Phone #: _____ Email: _____

Medical Insurance Company: _____

Policy Holder: _____

Identification, Policy and/or Group Number(s): _____

Medical Conditions That Could Require Emergency Care: _____

Current Medications: _____

Allergies to Medications: _____

Allergies to Food: _____

**Parents must provide allergy and/or asthma medications to the school.*

Emergency Local Area Contact #1

Name(s): _____ Relationship to Student: _____

Work or Cell Phone #: _____ Home Phone #: _____ Email: _____

Address: _____

Emergency Local Area Contact #2

Name(s): _____ Relationship to Student: _____

Work or Cell Phone #: _____ Home Phone #: _____ Email: _____

Address: _____

Emergency Local Area Contact Outside of the DC Area

Name(s): _____ Relationship to Student: _____

Work or Cell Phone #: _____ Home Phone #: _____ Email: _____

Address: _____

Date

Signature of Parent(s) / Legal Guardian(s)