APS EMERGENCY HEALTH FORM

(ONE PER STUDENT)

STUDENT'S LAST NAME FIRST NAME MIDDLE INITIAL BIRTH DATE GRADE

ADDRESS (include City/Sate/Zip)

HOME TELEPHONE WORK TELEPHONE (Father) WORK TELEPHONE (Mother)

EMPLOYMENT INFORMATION **FATHER**: (if none, please write 'none')
EMPLOYER NAME/ADDRESS

HEALTH INSURANCE COMPANY:

EMPLOYMENT INFORMATION **MOTHER**: (if none, please write 'none')
EMPLOYER NAME/ADDRESS

HEALTH INSURANCE COMPANY:
EMERGENCY CONTACTS: (at least two besides parents)

CONTACT'S LAST NAME FIRST NAME ADDRESS TELEPHONE NUMBER

CONTACT'S LAST NAME FIRST NAME ADDRESS TELEPHONE NUMBER

MEDICAL INFORMATION:
IS THE CHILD ALLERGIC TO ANY MEDICINES? YES NO
(if YES, please list them)

DOES THE CHILD HAVE ANY SERIOUS HEALTH CONDITIONS? YES NO
(if YES, please list them)

MAY WE GIVE THE CHILD ASPIRIN? YES NO

MAY WE ADMINISTER FIRST AID INCLUDING AMBULANCE? YES NO

DO YOU AUTHORIZE THE HOSPITAL OR DOCTOR TO ADMINISTER
MEDICAL TREATMENT AS NEEDED? YES NO

DOCTOR'S NAME ADDRESS TELEPHONE NUMBER

DENTIST'S NAME ADDRESS TELEPHONE NUMBER

HOSPITAL'S NAME ADDRESS TELEPHONE NUMBER

APS does not pay any expenses, medical or otherwise, of students who are injured at school or school-sponsored activities. APS is not responsible for any actions or injuries of any student.

AUTHORIZED SIGNATURE: (Parent or Guardian)

DATE