

North Technical High School Emergency Contact Form

School Year: 2012-13 If half-day, student what is your home school? _____

Students Information:

Last Name: _____ First Name: _____
Home Phone# _____ Cell Phone #: _____
Home Address: _____ City, State, Zip: _____
Date of Birth _____ Social Security #: _____ Male Female
Because some of our students live with someone other than their parent(s), please indicate with who you reside.
Name: _____ Relationship: _____ Phone: _____

Parent/Guardian #1

Relationship to student: _____
Last Name: _____ First Name: _____
Home Phone# _____ Cell Phone #: _____
Home Address (if different from student) : _____ City, State, Zip: _____
Employer: _____ Employer work #: _____

Parent/Guardian #2

Relationship to student: _____
Last Name: _____ First Name: _____
Home Phone# _____ Cell Phone #: _____
Home Address (if different from student) : _____ City, State, Zip: _____
Employer: _____ Employer work #: _____

FOR EMERGENCY USE WHEN PARENT CANNOT BE LOCATED

Relative or Friend's Name: _____ Relationship _____ Phone _____
Relative or Friend's Name: _____ Relationship _____ Phone _____
Relative or Friend's Name: _____ Relationship _____ Phone _____

EMERGENCY PROCEDURE: In case of illness requiring medical care, you have my permission to obtain such care from the nearest hospital and to release personally identifiable information regarding my child. I agree to pay all expenses incurred in such emergency care.

Hospital _____ Phone _____
Doctor _____ Phone _____ Dentist _____ Phone _____
Insurance Plan _____ Membership Number _____ Expiration Date _____

Signature Required _____ **Date** _____
(Parent or guardian)

HEALTH INFORMATION FORM

(To be complete by parent or guardian prior to entry into North Tech)

Does pupil have a history of any of the following: Asthma; Diabetes; Heart Condition; Convulsive disorder
Allergies (list) _____
Other Medical Problems: _____

Is pupil on any medication? yes no If yes, list name, time & amounts given: _____

Hearing Loss? yes no Wearing Hearing Aids? yes no Wearing contact lenses? yes no
Wearing glasses? yes no Date of last physical exam? _____