

# Village Gate Children's Academy Pupil Emergency Information Card

Student's Legal Name: \_\_\_\_\_

Birthdate: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Birthplace: \_\_\_\_\_ Grade: \_\_\_\_\_

Address: \_\_\_\_\_

Home phone # \_\_\_\_\_ Mother's cell # \_\_\_\_\_ Father's cell# \_\_\_\_\_

Mother's Email: \_\_\_\_\_ Father's Email: \_\_\_\_\_

Mother's Name, Occupation & Employer: \_\_\_\_\_

Father's Name, Occupation & Employer: \_\_\_\_\_

Student lives with: Mother  Father  Both

Alternate Address: \_\_\_\_\_

Siblings and their ages: \_\_\_\_\_

## OTHER PERSONS AUTHORIZED TO PICK UP MY CHILD IN AN EMERGENCY (must be at least 18 yrs of age)

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

Name(s) of persons authorized by current **COURT ORDER** (on file at school office) who **DO NOT** have access to the pupil:

## STUDENT HEALTH INFORMATION

Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Physician Address: \_\_\_\_\_

Dentist Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Dentist Address: \_\_\_\_\_

**If your child is seriously ill or injured and you cannot be reached, the paramedics will be called and your child will be transported to the hospital by ambulance.**

This pupil's doctor, hospital or dentist may give emergency treatment: YES  NO

Insurance Provider: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Policy / Group Plan Number: \_\_\_\_\_

## Health Problems: (please check all areas concerning your child's current health)

- Allergies : (Please specify) \_\_\_\_\_
- Diabetes, since age \_\_\_\_\_
- Asthma: Mild / Moderate/ Severe Requires an inhaler : YES/ NO Additional info: \_\_\_\_\_
- Seizure Disorder - please describe: \_\_\_\_\_
- Heart Problems - please describe: \_\_\_\_\_
- Urinary Tract Problems - please describe: \_\_\_\_\_
- Physical Education Limits - please describe: \_\_\_\_\_
- Other - please specify: \_\_\_\_\_
- Wears Glasses for \_\_\_\_\_ Exam Date: \_\_\_\_\_
- Hearing Problems: \_\_\_\_\_ Exam Date: \_\_\_\_\_

Is the student on any medications: YES  NO  Name & Frequency of Medication: \_\_\_\_\_

**HEALTH PROBLEMS:** Above health problems can be shared with appropriate staff : YES  NO

**SCHOOL DIRECTORY:** I give permission to put our information in the school directory: YES  NO

**Parent / Guardian signature indicates agreement with above statements and that all information has been read.**

Parent / Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_