

STUDENT EMERGENCY CARD

Please print changes  
Sign and date the bottom  
of the card

NORTHVILLE PUBLIC SCHOOLS

Teacher /  
Counselor: \_\_\_\_\_  
Grade: \_\_\_\_\_

Medical Problem

Legal Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Gender \_\_\_\_\_ Birth Date \_\_\_\_\_

CURRENT Address \_\_\_\_\_ Apt. # \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ Area Code & Home Phone No. \_\_\_\_\_

STUDENT RESIDES WITH (Please Circle) MOTHER FATHER BOTH PARENTS LEGAL GUARDIAN  
**Number the boxes next to the phone numbers in the order to be called (1-10)**

PARENT / LEGAL GUARDIAN \_\_\_\_\_ e-mail: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Address \_\_\_\_\_ Apt. # \_\_\_\_\_

Relationship to student: \_\_\_\_\_ Mother, Father, Step Mother, Step Father, Foster Parent,  
Legal Guardian, Aunt, Uncle, Grandparent \_\_\_\_\_ City \_\_\_\_\_ State Zip \_\_\_\_\_

\_\_\_\_\_  
Type: \_\_\_\_\_

Type:  
**Work**  
**Cellular**  
**Pager**  
**Residential** – list only if  
different than student's  
Home Phone Number

\_\_\_\_\_  
Type: \_\_\_\_\_

\_\_\_\_\_  
Type: \_\_\_\_\_

\_\_\_\_\_  
Type: \_\_\_\_\_

PARENT / LEGAL GUARDIAN \_\_\_\_\_ e-mail: \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Address \_\_\_\_\_ Apt. # \_\_\_\_\_

Relationship to student: \_\_\_\_\_ Mother, Father, Step Mother, Step Father, Foster Parent,  
Legal Guardian, Aunt, Uncle, Grandparent \_\_\_\_\_ City \_\_\_\_\_ State Zip \_\_\_\_\_

\_\_\_\_\_  
Type: \_\_\_\_\_

Type:  
**Work**  
**Cellular**  
**Pager**  
**Residential** – list only if  
different than student's  
Home Phone Number

\_\_\_\_\_  
Type: \_\_\_\_\_

\_\_\_\_\_  
Type: \_\_\_\_\_

\_\_\_\_\_  
Type: \_\_\_\_\_

**ADDITIONAL LOCAL PERSONS TO WHOM YOUR CHILD MAY BE RELEASED**

Name \_\_\_\_\_ Phone No. \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone No. \_\_\_\_\_ Relationship \_\_\_\_\_

- Check here if permission is denied for your child's name and/or picture to be used for public information releases including the district's website
- Check here if family's primary language is not English
- Check here if permission is given to release your child's name/address/phone under the Freedom of Information Act

**STUDENT HEALTH INFORMATION:**

Family Doctor \_\_\_\_\_ Address \_\_\_\_\_ Phone No. \_\_\_\_\_

Name of Health Insurance Carrier: \_\_\_\_\_

**HEALTH CONCERNS:**

- Allergies \_\_\_\_\_
- Asthma \_\_\_\_\_ Please specify type (medication/food/insect, environmental, other) and reaction
- Epi-Pen \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Seizures \_\_\_\_\_
- Other \_\_\_\_\_

**MEDICATION:** List all medication the student uses \_\_\_\_\_

Physician authorization required if medication is administered at school. See Student Handbook. Health information provided on this form and information submitted on physical health appraisals may be shared with school personnel who are involved with health and safety of your child. If school personnel are unable to reach me or a person who I have designated, I hereby authorize the school to secure emergency medical treatment as necessary. I agree to pay all expenses incurred by the emergency care.

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

Student Name:

Please complete this portion each year

Rev. 04/08/2009

Please complete this portion each year