Emergency Care Card

Grade_____ Teacher_____ Bus# _____ Age _____

Student's Name_____ Date of Birth_____
Last First Middle

Physical Address: _____
Street City Zip

Mailing Address: _____
P.O. Box City Zip

Home Phone: _____ Cell Phone: _____

Parent/Guardian _____ Employer_____Phone#_____

Parent/Guardian _____ Employer _____Phone# _____

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OVER

Emergency Care Card

Family Physician _____ Phone#_____ Dentist _____
Medications given at home (on a regular basis) _____
Please check any existing health conditions:

_____ADD/ADHD
_____**Allergies (explain)** _____
_____Asthma
___Uses Inhalers
___Uses Nebulizer
_____Bleeding Problem
_____Diabetes
_____Fainting Spells
_____Hearing Problems
_____Heart Problems

_____Headaches/Migraines
_____Seizures
_____Speech Problems
_____Vision Problems
Other Problems _____
_____
_____
_____

_____**Bee Sting Allergy**
____Swelling or redness
____Difficulty Breathing
_____Swelling of lips& eyes
_____Hives
Describe your child's reaction:
_____
Uses an EpiPen: ___Yes ___No

Please list all brothers & sisters living in the home:

_____ _____
Name Birth Date School Name Birth Date School

_____ _____
Name Birth Date School Name Birth Date School

I give permission for my child's health information to be shared with appropriate school staff. Yes ___ No ____

PARENT/GUARDIAN SIGNATURE _____ DATE _____