ALLERGY /EMERGENCY INFORMATION

1. Student Information

Legal Name	Last:	First:	Middle:	Gender:	Birthdate: (mm/dd/yyyy) / /	Grade entering:

Address:	Street: (Apt./Unit #)	City:	State:	Zip Code

2. Allergy History/information: This information is private and will only be used to provide care and in an emergency.

Please list any current allergies Or Chronic health conditions and symptoms previously exhibited:

Allergy/Condition:____

Symptoms:____

Allergy/Condition:____

Symptoms:____

Allergy/Condition:____

Symptoms:____

*can group allergies/conditions by symptoms

Does Your child take or carry any emergency medications?

If Yes Please Explain: (Include dosage of medications and if prescribed or over counter)

____

____

____

____

*Please Note if student carries emergency medications with them

Other Comments:

3. Emergency Contact Information:

This information is being collected to provide for the student's health and safety at VBS. Refusal of information could result in the staff's inability to contact you in case of an emergency. In the event of an emergency, the staff may secure emergency services for your child at parent expense. All attempts will be made to contact parents immediately in case of an emergency.

Emergency Contact(s) that live(s) with the student:

Legal Name	Last:	First:	Middle:	Gender:	Relationship:

Home Phone:	( ) -	Cell Phone:	( ) -	Work Phone:	( ) -

Legal Name	Last:	First:	Middle:	Gender:	Relationship:

Other Emergency Contact(s):

Home Phone:	( ) -	Cell Phone:	( ) -	Work Phone:	( ) -

Legal Name	Last:	First:	Middle:	Gender:	Relationship:

Home Phone:	( ) -	Cell Phone:	( ) -	Work Phone:	( ) -

Primary E-mail address: Please list only one e-mail address	Family Doctor Name	Family Doctor Phone Number
		( ) -

4. Parent/legal guardian certification:

I CERTIFY THE INFORMATION GIVEN ABOVE IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE AND BELIEF.

PRINTED NAME____________________SIGNATURE____________________DATE__________