Side A

Dual Parent Notification ☐

STUDENT CLINIC CARD

INSTRUCTIONS: (**PLEASE PRINT)** This card must be completed by the parent or guardian and returned to the school

LEGAL NAME OF STUDENT (Last, First, Middle Init.)	Social Security Number	Male: / Female:	Date of Birth	Grade
ADDRESS: STREET APT/LOT# CITY ZIP	HOME PHONE	Glasses: / Contacts:	PICTURE OF STUDENT:	
MOTHER'S NAME/LEGAL GUARDIAN(circle one)	Home Phone: / Pager:	Business Phone: / Cell Phone:		
FATHER'S NAME/LEGAL GUARDIAN(circle one)	Home Phone: / Pager:	Business Phone: / Cell Phone:		
STEP PARENT'S NAME (if applicable)	Home Phone: / Pager:	Business Phone: / Cell Phone:	Names & Grades of Siblings at This School: 1.	
NAME OF PERSON*WHO WILL ASSUME RESPONSIBILITY IF PARENT CANNOT BE REACHED PHONE:	#1 NAME:		2	
NAME OF PERSON*WHO WILL ASSUME RESPONSIBILITY IF PARENT CANNOT BE REACHED PHONE:	#2 NAME:		3	
			4	
PHYSICIAN'S NAME PHONE	HOSPITAL PREFERENCE	DATE OF LAST TETANUS SHOT	MEDICATIONS: Yes No Please List:	
DENTIST'S NAME PHONE	ALLERGIES - Please List any your child may have		Other Health Problems:	

Is there any court order restricting access to the student an/or student records? _____ Yes _____ No

If yes, please provide the school with a certified copy.

In case of accident or serious illness, the school will contact the parent/guardian.

If the school is unable to contact the parent/guardian or person(*) designated above, the school will contact the physician or will make necessary arrangements for immediate treatment. Payment of fees will be assumed by the parent/guardian.

I have reviewed and understand the conditions of the clinic emergency information card.

Signature of Parent/Guardian **Date:**

Side B

STUDENT CLINIC CARD

NAME: _____ **GRADE:** _____

Last First

DATE	REASON	TIME IN	TIME OUT	DISPOSITION	HEALTH AIDE