

## STUDENT EMERGENCY CARD 2019-2020

Student Name (Last, First MI)	(Date of Birth)	(Age)	(Grade Entering)
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Father/Guardian Name: _____ Address: _____ (Street)                    (City/State)                    (Zip) Home Phone: _____ <input type="checkbox"/> Work Phone: _____ <input type="checkbox"/> Cell Phone: _____ <input type="checkbox"/> Employer: _____ Email: _____ Goes to cell? <input type="checkbox"/>	Mother/Guardian Name: _____ Address: _____ (Street)                    (City/State)                    (Zip) Home Phone: _____ <input type="checkbox"/> Work Phone: _____ <input type="checkbox"/> Cell Phone: _____ <input type="checkbox"/> Employer: _____ Email: _____ Goes to cell? <input type="checkbox"/>
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\*Please check the box for the best way to contact you.

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### PERSONS TO CONTACT IN CASE OF EMERGENCY WHEN PARENT/GUARDIAN CANNOT BE REACHED

(Name)	(Home)	(Work)	(Cell)	(Relationship)
(Name)	(Home)	(Work)	(Cell)	(Relationship)
(Name)	(Home)	(Work)	(Cell)	(Relationship)

### MEDICAL/HEALTH HISTORY INFORMATION

Please read carefully and fill in the necessary information. This information is confidential but may be necessary to share among pertinent faculty for activities which overlap.

ALLERGIES (Medications, Food, Insect Bites, etc.): \_\_\_\_\_

Medical Conditions, Diagnoses: \_\_\_\_\_

Medications taken daily (at home or school) or as needed. Include name, dosage and frequency: \_\_\_\_\_

Daily Monitoring or Procedures (glucose, nebulizer, etc.): \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Dentist's Name: \_\_\_\_\_ Office Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

Insurance Carrier: \_\_\_\_\_ Group Policy #: \_\_\_\_\_

I, \_\_\_\_\_, do hereby authorize the School Administration to render first aid for illness or injury to my child named above. In the event of a medical emergency, I authorize the School Administration to have my child transported to the nearest available hospital/emergency care center for emergency medical or surgical treatment and to contact one of the persons listed above. I further authorize the release of the above medical information to all medical personnel providing treatment. I agree to be solely responsible for the payment of all expenses incurred in such an emergency.

I do hereby release, hold harmless and indemnify The Regis School, the Regis Board of Directors, the Head of School, Mr. Dennis Phillips, and his successors in office, and all officers, agents, employees or representatives ("Released Parties") from any and all liability, claims, losses or expenses arising from personal injury, death or loss of or damage to property arising from any medical treatment received and/or transportation to the nearest available hospital/emergency care center, including any claims allegedly caused or contributed to by the negligence or willful misconduct of the Released Parties.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date