BEDFORD PUBLIC SCHOOLS
Emergency Information Card

NAME:_____

STUDENT NAME:_____GRADE_____ROOM #_____BUS #_____
(Last) (First) (Middle)
HOME ADDRESS:_____
(Street) (City/Town) (Zip Code)
DATE OF BIRTH:_____PLACE OF BIRTH:_____ STATE WARD: Yes____ No____

With Whom Does Child Reside: _____ Relationship: _____

PARENT'S FULL NAME:_____HOME #:_____WORK #_____
MOBILE PHONE #:_____E-MAIL ADDRESS:_____
ADDRESS: (If different than the student)_____
OCCUPATION: _____ EMPLOYER: _____

PARENT'S FULL NAME:_____HOME #:_____WORK #:_____
MOBILE PHONE #:_____E-MAIL ADDRESS:_____
ADDRESS: (If different than the student)_____
OCCUPATION: _____ EMPLOYER: _____

GUARDIAN'S FULL NAME:_____HOME #:_____WORK #:_____
MOBILE PHONE #:_____E-MAIL ADDRESS:_____
ADDRESS: (If different than the student)_____
OCCUPATION: _____ EMPLOYER: _____

SIBLINGS ATTENDING BEDFORD SCHOOLS (Name & Grade):_____

GRADE:_____

In case of accident, sudden illness or crisis, name of person who could assume responsibility if you cannot be reached (Please notify person):
1. _____
HOME #:_____WORK #:_____MOBILE #:_____
2. _____
HOME #:_____WORK #:_____MOBILE #:_____

In the event that the parents cannot be reached, I request that (Check one):

_____ The school contact the person indicated above who will assume responsibility for my child.
_____ The school contact the person indicated above who will assume responsibility only if the school determines there is an emergency.

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Medical Information: **Student Name: _____ School: _____**

Does your child have specific health considerations? i.e., allergic to bee stings, other allergies?

Yes_____ No_____ Please specify:_____(Please contact School Nurse with specifics)

Other Information: _____

_____

_____

Please complete: Child's Insurance Plan:_____Plan #:_____

Doctor:_____ Office #:_____

Dentist:_____ Office #:_____

Medical Treatment Permission:
In the case of illness or accident, first aid and appropriate care will be provided. Your signature below indicates permission for said first aid and appropriate care to be given until family or physician can be reached.

_____ _____

Signature Date