

**VALLEY LUTHERAN HIGH SCHOOL EMERGENCY INFORMATION**

*PLEASE PRINT*

Student Last Name, First Name \_\_\_\_\_  
Birth Date \_\_\_\_\_ Sex \_\_\_\_\_ Grade \_\_\_\_\_  
Address \_\_\_\_\_  
Home Phone \_\_\_\_\_

**Parent Information**

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_  
Work Number \_\_\_\_\_ Work Number \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Emergency Contacts**

Please give the names of two local relatives or friends who have agreed to assume responsibility of your child in case of illness/accident until you can be reached.

Name \_\_\_\_\_ Name \_\_\_\_\_  
Address \_\_\_\_\_ Address \_\_\_\_\_  
Home Phone \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Health Information**

Physician to be called if student becomes ill or has an accident and you cannot be reached.

Physician's Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_  
Hospital Preference \_\_\_\_\_

**Insurance Information**

Insurance Co. Name \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Group Number \_\_\_\_\_

List any special health conditions, allergies or daily medication: \_\_\_\_\_

List any immunizations received last year: Type: \_\_\_\_\_ Date: \_\_\_\_\_  
Type: \_\_\_\_\_ Date: \_\_\_\_\_

My child is allowed to take Tylenol as needed. \_\_\_\_\_ Yes \_\_\_\_\_ No  
My child is allowed to take Ibuprofen as needed. \_\_\_\_\_ Yes \_\_\_\_\_ No

If an emergency requiring medical action or treatment occurs and neither the parent nor the family physician can be reached for consent, the parents hereby consent to the rendering of such medical services for this student as shall be necessary in the medical opinion of the doctor rendering such service. It is further understood that any expenses incurred will be paid for by insurance of the parent of the student.

Date \_\_\_\_\_ Parent Signature \_\_\_\_\_