

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 _____