LA PRYOR ELEMENTARY
EMERGENCY HEALTH INFORMATION RECORD

STUDENT LAST NAME:	STUDENT FIRST NAME:
DATE OF BIRTH	GRADE LEVEL
MAILING ADDRESS	CITY/STATE/ZIP
GUARDIAN NAME	GUARDIAN NAME
GUARDIAN PHONE	GUARDIAN PHONE
STUDENT'S PHYSICIAN	PHYSICIAN PHONE
STUDENT'S DENTIST	DENTIST PHONE
ALTERNATIVE CONTACT NAME	CONTACT NUMBER
ALTERNATIVE CONTACT NAME	CONTACT NUMBER
IS STUDENT TAKING ANY MEDICATION? ☐ YES ☐ NO IF YES, PLEASE LIST:	DOES STUDENT HAVE ANY CHRONIC HEALTH PROBLEMS? ☐ YES ☐ NO IF YES, PLEASE LIST:
IS STUDENT LIMITED TO ANY PHYSICAL ACTIVITIES? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN:	DOES STUDENT HAVE ANY ALLERGIES (FOOD OR OTHERWISE)? ☐ YES ☐ NO IF YES, PLEASE EXPLAIN
ANY OTHER CONCERNS YOU WOULD LIKE TO BRING TO OUR ATTENTION?	
IF THE PARENTS AND AUTHORIZED PHYSICIAN NAMED ABOVE CANNOT BE REACHED AT THE TIME OF AN EMERGENCY, AND IF IMMEDIATE OBSERVATION OR TREATMENT IS URGENT IN THE JUDGEMENT OF THE SCHOOL AUTHORITIES, DO YOU AUTHORIZE AND DIRECT THE SCHOOL AUTHORITIES TO SEND THE STUDENT (PROPERLY ACCOMPANIED) FOR TREATMENT TO THE HOSPITAL OR DOCTOR MOST EASILY ACCESSIBLE? ☐ YES ☐ NO	
DO YOU AGREE TO BE FINANCIALLY RESPONSIBLE FOR ALL EXPENSES INCURRED FOR TREATMENT UNDER THE CIRCUMSTANCES DESCRIBED ABOVE? ☐ YES ☐ NO	
IF ANY ANSWERS TO THE ABOVE QUESTIONS ARE NO, PLEASE EXPLAIN WHAT ACTIONS YOU DESIRE SCHOOL AUTHORITIES TO TAKE:	

GUARDIAN/PARENT SIGNATURE ____________________ DATE ____________