



# STUDENT CLINIC CARD

INSTRUCTIONS: (PLEASE PRINT) This card must be completed by the parent or guardian and returned to the school

LEGAL NAME OF STUDENT (Last, First, Middle Init.)		Social Security Number		Male:	Date of Birth	Grade
				Female:		
ADDRESS: STREET APT/LOT# CITY ZIP		HOME PHONE		Glasses:	PICTURE OF STUDENT:	
				Contacts:		
MOTHER'S NAME/LEGAL GUARDIAN(circle one)		Home Phone:	Business Phone:			
		Pager:	Cell Phone:			
FATHER'S NAME/LEGAL GUARDIAN(circle one)		Home Phone:	Business Phone:		Names & Grades of Siblings at This School: 1.	
		Pager:	Cell Phone:			
STEP PARENT'S NAME (if applicable)		Home Phone:	Business Phone:			
		Pager:	Cell Phone:			
NAME OF PERSON*WHO WILL ASSUME RESPONSIBILITY IF PARENT CANNOT BE REACHED PHONE:				#1 NAME:	2	
NAME OF PERSON*WHO WILL ASSUME RESPONSIBILITY IF PARENT CANNOT BE REACHED PHONE:				#2 NAME:	3	
					4	
PHYSICIAN'S NAME	PHONE	HOSPITAL PREFERENCE	DATE OF LAST TETANUS SHOT	MEDICATIONS: Yes No Please List:		
DENTIST'S NAME	PHONE	ALLERGIES - Please List any your child may have		Other Health Problems:		

Is there any court order restricting access to the student an/or student records?                      Yes                      No

If yes, please provide the school with a certified copy.

In case of accident or serious illness, the school will contact the parent/guardian.

If the school is unable to contact the parent/guardian or person(\*) designated above, the school will contact the physician or will make necessary arrangements for immediate treatment. Payment of fees will be assumed by the parent/guardian.

I have reviewed and understand the conditions of the clinic emergency information card.

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

\_\_\_\_\_  
Date: