

ULSTER COUNTY BOCES CAREER & TECHNICAL CENTER
EMERGENCY INFORMATION FORM
THIS SECTION TO BE COMPLETED BY PARENT/GUARDIAN

Student's Name: _____ High School: _____

Mailing Address: _____

Date of Birth: ___/___/___ Parent/Guardian Phone #: _____ Student Cell #: _____

Is student taking any medication? YES _____ NO _____

Name of medication & dosage: _____

Reason for medication: _____ Time medication is given: _____

Allergies: _____ Medical conditions that require care: _____

Doctor's Name: _____ Phone number: _____

Mother's Name: _____ Primary #: _____
Work #: _____ Cell #: _____

Father's Name: _____ Primary #: _____
Work #: _____ Cell #: _____

Legal Guardian's Name: _____ Primary #: _____
Work #: _____ Cell #: _____

Emergency Contact Person 1: _____ Phone #: _____
Not listed above – Name & relationship

Emergency Contact Person 2: _____ Phone #: _____
Not listed above – Name & relationship

Date

Signature of Parent/Guardian

THIS SECTION TO BE COMPLETED BY SCHOOL NURSE

Is there a condition present that requires special care? YES _____ NO _____

List any acute or chronic illnesses or medical conditions: _____

Physical restrictions: _____ Allergies: _____

Medication: _____

Date of last Tetanus injection: ___/___/___

Date of 1st MMR ___/___/___

Date of 1st Polio Vaccination ___/___/___

Date of 2nd MMR ___/___/___

School Nurse Signature: _____ Date: ___/___/___