Emergency Medical Card

Student name: _____ Date of Birth: ___ / ___ / _____

Name of Parent/Guardian: _____

Cell Phone #: _____ Home/Work Phone #: _____

Name of Physician: _____ Phone: _____

Name of Insurance Company: _____ Policy #: _____

Preferred Medical Facility: _____

Allergies: Yes ___ No ___ Type: _____

List medications: _____