

# BEST Emergency/Medical Form



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## STUDENT INFORMATION

Legal Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Last First Middle Suffix (Jr., Sr., etc.) (mm/dd/yyyy)

Street Address \_\_\_\_\_ Apt. # \_\_\_\_\_

City/Town \_\_\_\_\_ State/Province \_\_\_\_\_ Zip/Postal Code \_\_\_\_\_

## PARENT/GUARDIAN #1

Parent  Guardian \_\_\_\_\_  
Title Last First Middle Suffix

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

## PARENT/GUARDIAN #2

Parent  Guardian \_\_\_\_\_  
Title Last First Middle Suffix

Cell Phone \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Emergency Contacts: Please list two contacts that will be called **ONLY** if either parent cannot be reached in an emergency.

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name: \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

## PHYSICIAN INFORMATION

Physician/Pediatrician: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialist: \_\_\_\_\_ Reason: \_\_\_\_\_ Phone: \_\_\_\_\_

Specialist: \_\_\_\_\_ Reason: \_\_\_\_\_ Phone: \_\_\_\_\_

Initials \_\_\_\_\_

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## HEALTH INSURANCE INFORMATION

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

## MEDICAL INFORMATION

Allergies: \_\_\_\_\_

Medicines taken regularly (including OTC medicines): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Medical restrictions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Any other issues BEST needs to be aware of (mental, emotional, behavioral, etc.): \_\_\_\_\_

\_\_\_\_\_

**\*BEST Skills Academy does NOT have a school nurse.**

**\*All medications taken at school must be self-administered.**

Initials \_\_\_\_\_

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The Executive Director may share health information with individuals who have responsibilities for my child. I authorize BEST staff to contact the person named on this form and authorize the named physician to render to my child whatever emergency treatment deemed necessary. If the physician, other persons named above, or parent cannot be reached, BEST may take whatever action they deem necessary for the health of my child. I will not hold BEST responsible for the emergency care and/or transportation of my child. I will keep the school informed of any changes on this form.

**\*Please attach immunization records**

**Parent Signature**

**Date**

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