BEST Emergency/Medical Form

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**