BEST Emergency/Medical Form 2025-2026

BE ST Skills Academy

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 _____

BEST Emergency/Medical Form 2025-2026

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 _____

BEST Emergency/Medical Form 2025-2026

I acknowledge and authorize the Executive Director of BEST Skills Academy to share my child's health information with responsible individuals as deemed necessary. In the event of an emergency, I authorize BEST staff to contact the person named on this form and authorize the named physician to provide emergency treatment for my child as deemed necessary.

If neither the physician, nor the individuals named above, nor the parent can be reached, BEST may take appropriate action as deemed necessary for the health and safety of my child. I fully release BEST from any responsibility related to emergency care and/or transportation of my child. I agree to promptly inform the school of any changes to the information on this form.

***If there are no immunization records on file, please attach them to this form.**

Parent Signature **Date**