ACTIVITY: _____ SCHOOL YEAR: 20____ - 20____

GALENA PARK I.S.D. EMERGENCY CARD

PRINT IN INK

Student's Name: _____ _____ _____
Last First Middle

DOB: _____ Sex: _____ Age: _____ Home Phone: _____

Social Security Number: _____-_____-____ Student ID #: _____ State ID#:_____

Father's Name: _____ Mother's Name: _____

Work #: _____ Work #: _____

Cell #: _____ Cell #: _____

Address: _____ City: _____ State: _____ Zip: _____

Emergency Contact (NOT GUARDIAN):

_____ _____ _____
Last First Relationship

Home #: _____ Work #: _____ Cell #: _____

Known Allergies: _____

Known Medical Conditions: _____

Medications Taken Daily: _____

Asthma: Yes or No Inhaler: Yes or No Type: _____

Insurance Information

Is your child covered under a healthcare insurance policy: YES or NO

CHIP: _____ MEDICAID: _____ Plan of CHIP/MEDICAID: _____

Insurance Company: _____

Is your insurance policy a HMO or PPO? _____

If it is an HMO, List your Primary Care Physician:

Name: _____ Number: _____

Insurance Co. Claims Address: _____
P.O. BOX City State Zip

Insurance Phone Number: _____

Policy/ID Number: _____ Group Number: _____

Policy Holders Name: _____ DOB: _____

ALL THIS INFORMATION IS LISTED ON THE INSURANCE CARD/MEDICAID PAPERS

If, in the judgment of any representatives of the school, the above student needs immediate care and treatment as a result of any injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given to said student by any physician, trainer, nurse, hospital, or school representative; and I do hereby agree to indemnify and save harmless the school and any representative from any claim by any person whosoever on account of such care and treatment of said student. Your signature on this form gives the authorization that is necessary for the school district, its representative to share information concerning medical diagnosis and treatment for your child.

_____ _____ _____
Print Parent's or Guardian's Name Signature Date