Burrell School District Emergency Care Card

Student's Name:	Student #:
DOB:	Gender:
School:	Grade:

FAMILY 1 INFORMATION	
Parent/Guardian Name 1:	Relationship:
Guardian 1 Email:	
Address:	
Family 1 Primary Phone:	
Guardian 1 Work Phone (Second Phone):	
Guardian 1 Cell Phone (Third Phone):	
Parent/Guardian Name 2:	Relationship:
Guardian 2 Email:	
Address:	
Guardian 2 Work Phone (Second Phone):	
Guardian 2 Cell Phone (Third Phone):	

FAMILY 2 INFORMATION	
Parent/Guardian Name 1:	Relationship:
Guardian 1 Email:	
Address:	
Family 2 Primary Phone:	
Guardian 1 Work Phone (Second Phone):	
Guardian 1 Cell Phone (Third Phone):	
Parent/Guardian Name 2:	Relationship:
Guardian 2 Email:	
Address:	
Guardian 2 Work Phone (Second Phone):	
Guardian 2 Cell Phone (Third Phone):	

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EMERGENCY CONTACT INFORMATION: ****Please Note:** Parents are automatically listed as Emergency Contacts.

Please select ***TWO ADDITIONAL*** responsible adults who will provide transportation and temporary care of your child if you cannot be reached

Additional Emergency Contact 1 Name: _____

Relationship: _____

Emergency Contact 1 Primary Phone: _____ Second Phone (Work): _____

Third Phone (Cell): _____

Emergency Contact 1 Address: (Street, City, State, Zip) _____

_____

Additional Emergency Contact 2 Name: _____

Relationship: _____

Emergency Contact 2 Primary Phone: _____ Second Phone (Work): _____

Third Phone (Cell): _____

Emergency Contact 2 Address: (Street, City, State, Zip) _____

_____

In case of an emergency and it is necessary to call a Physician or Dentist, please contact:

Physician's Name: _____ Phone: _____
Dentist's Name: _____ Phone: _____

It is necessary to inform the school of any medical conditions. I authorize the release of this information to appropriate school personnel as necessary.
Medical Condition(s): _____
_____

Medication (s): _____
_____

Since the care and treatment of any child is parental responsibility, I understand that every effort will be made to contact either parent first in case your child becomes ill or is injured at school. Depending upon the nature or severity of the injury, the attending nurse (or in her absence, school personnel) is authorized by you (parent/guardian) to send the student named on this form to an appropriate medical facility as determined by the emergency response team.
The school physician/dentist/nurse has my permission to do the required examinations (physical, dental, scoliosis) if appropriate forms have not been completed by my private physician/dentist and returned to the nurse.

If any parent/guardian of Family 1 or 2 does **NOT** have access to the Internet and/or an email address, please indicate here: _____

Date: _____ Print Name of Parent/Guardian _____

Signature of Parent/Guardian: _____