

2629 Horseshoe Drive, South,
Naples, FL 34104
239-261-6227
Fax: 239-261-6227
E: nacs@flcoe.org
www.naplesacs.org



STUDENT EMERGENCY INFORMATION FORM

STUDENT

PLEASE PRINT CLEARLY.

NAME: _____ (Last) _____ (First) _____ (MI) _____ (Date of Birth) _____ (Age) _____ (Sex) _____ (Grade)

Social Security Number: _____ Weight _____

Father/Guardian Name: _____ Mother/Guardian Name: _____

Address: _____ Address: _____
(Street) (City/State) Zip (Street) (City/State) (Zip)

Phone: _____ Phone: _____
(Home) (Work) (Cell) (Home) (Work) (Cell)

Father's Employer: _____ Mother's Employer: _____

**LIST PERSONS TO BE CONTACTED IN CASE OF EMERGENCY
WHEN PARENT/GUARDIAN CANNOT BE REACHED**

Contact Name	Telephone #'s	Relationship	Employer
_____	(Home) (Work) (Cell)	_____	_____
_____	(Home) (Work) (Cell)	_____	_____
_____	(Home) (Work) (Cell)	_____	_____

MEDICAL INFORMATION

DOCTOR'S NAME: _____ OFFICE #: _____ EMERGENCY #: _____

DENTIST'S NAME: _____ OFFICE #: _____ EMERGENCY #: _____

INSURANCE CARRIER: _____ GROUP POLICY #: _____

PREFERRED HOSPITAL or HEALTHCARE FACILITY: _____

ALLERGIES (drugs, food, environmental): _____

MEDICAL CONDITIONS (ex. diabetes): _____

MEDICATION TAKEN DAILY OR AS NEEDED (name, dosage & frequency): _____

DAILY MONITORING REQUIRED (glucose monitoring)

I, _____, do hereby authorize school administration to render first aid for illness or injury to my child named above. In the event of a medical emergency, I authorize school administration to have my child transported to the nearest hospital /emergency care center for emergency medical or surgical treatment and to contact my child's physician and one of the persons listed above. I further authorize the release of the above medical information to all medical personnel providing treatment. I agree to be solely responsible for the payment of all expenses incurred in such an emergency.

I do hereby release, hold harmless Naples Adventist Christian School and any of their employees or representatives ("Released Parties") from any and all liability, claims, losses or expenses arising from personal injury, death, or loss of or damage to property arising from any medical treatment received and/or transportation to the nearest hospital/emergency care center.

Signature of Parent/Guardian

Date Signed