Minnesota JCC

2024/2025 Program Year

# Student Emergency Form *(page 1 of 2)*

Child's Name_____ Birthdate_____Date of last DPT_____

Child's Address/City/Zip_____

Allergies/significant medical information_____

**Parent/Guardian 1 Name (First & Last)**_____

Address/City/Zip _____

Home Phone_____ Cell Phone _____

Work Phone_____ Email _____

**Parent/Guardian 2 Name (First & Last)**_____

Address/City/Zip _____

Home Phone_____ Cell Phone _____

Work Phone_____ Email _____

**PHYSICIAN**

Name_____

Phone_____

Address_____

**DENTIST**

Name_____

Phone_____

Address_____

**ALLERGIES/SPECIAL NEEDS**

Food and/or Medication Allergies/significant _____

Other Allergies_____

Additional Medical Concerns (asthma, etc.) _____

My child will need medication administered during the day:

Medication and Dosage_____ Time_____

Additional information_____

*please complete other side*

**TWO NON-PARENT/GUARDIAN EMERGENCY CONTACTS ARE REQUIRED.**

**1. Emergency contact/authorized individual who may pick up child:**

Name_____ Relationship_____

Phone_____

Address _____

**2. Emergency contact/authorized individual who may pick up child:**

Name_____ Relationship_____

Phone_____

Address _____

**3. Emergency contact/authorized individual who may pick up child: (optional)**

Name_____ Relationship_____

Phone_____

Address _____

People who may **NOT** pick up my child_____

**Emergency information must be updated once yearly.**

If parent and personal physician cannot be reached or are delayed in arriving, in the event of an emergency, I authorize appropriate hospital or my doctor's hospital named above to treat my child. The emergency contacts listed above are authorized to pick up my child.

**Parent/Guardian's Signature** _____

**Date** _____