



Minnesota JCC

2025/2026 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 _____