AMHERST CENTRAL SCHOOLS
STUDENT HEALTH EMERGENCY DATA

PLEASE PRINT:

STUDENT'S NAME_____ _____ _____
LAST **FIRST** **M.I.**

MEDICATIONS:_____ _____

_____ _____

ADDRESS:

_____

PHONE:_____ **DATE OF BIRTH:**_____

EMERGENCY PHONE NUMBERS:

MOTHER'S FULL NAME: _____ **CELL:**_____

MOTHER'S PLACE OF EMPLOYMENT:_____ **PHONE:**_____

FATHER'S FULL NAME: _____ **CELL:**_____

FATHER'S PLACE OF EMPLOYMENT: _____ **CELL:**_____

NEARBY RELATIVE'S NAME_____ **CELL:**_____

NEIGHBOR'S NAME: _____ **PHONE:** _____

PHYSICIAN'S NAME:_____ **PHONE:**_____

INSURANCE COMPANY:_____

INSURANCE ID #:_____