



Bloomfield Hills Schools

Athletics, Recreation
and Community Services

EMERGENCY INFORMATION RECORD

Last Name		First Name		Middle Name		<input type="checkbox"/> Male
						<input type="checkbox"/> Female
Address			City		Zip Code	
Birthdate			School		Grade	
Father's Full Name			Mother's Full Name			
Legal Guardian's Full Name			Residing With:			
			<input type="checkbox"/> Parents		<input type="checkbox"/> Father	
			<input type="checkbox"/> Guardian		<input type="checkbox"/> Mother	

EMERGENCY CONTACT PHONE NUMBERS

(Minimum Three Contacts – Number each item in order of desired action)

Please include area code with phone number

_____ Contact Mother at Home	() _____
_____ Contact Mother's Cell Phone	() _____
_____ Contact Mother at Place of Employment	() _____
_____ Contact Father at Home	() _____
_____ Contact Father's Cell Phone	() _____
_____ Contact Father at Place of Employment	() _____
_____ Contact Relative – Name: _____	() _____
_____ Contact Neighbor – Name: _____	() _____

Family Doctor's Name	Hospital of your choice in the event that injury needs immediate attention and no one can be located.
Family Doctor's Phone Number	

I agree to pay any and all charges which may become necessary during any emergency treatment and or pay any and all hospital charges if my child must be taken to the hospital should Bloomfield Hills Schools Athletics, Recreation, and Community Services program staff be unable to locate me by telephone at the time of said emergency.

Signature of the Parent _____ Date _____

GENERAL INFORMATION

Please fill out completely and accurately.

Hospitalization Company	Policy Number
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Are there any known allergies/chronic health problems that would affect your child's progress in a classroom situation? (Please check all that apply)

<input type="checkbox"/> Hearing	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Asthma
<input type="checkbox"/> Vision	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Allergies	<input type="checkbox"/> None
<input type="checkbox"/> Speech	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Bee Stings (Epi-Pen)	<input type="checkbox"/> Other _____

Is your child on any prescription medication that we should be aware of? Please explain.

If the medication needs to be taken during school hours, please complete the prescription medication form that can be obtained from the office.

Tetanus Toxoid Booster Up-To-Date (Check One): Yes No

ADDITIONAL COMMENTS

NOTE: If there is any change in the information on this form, which occurs during the school year, please contact Bloomfield Hills Schools Athletics, Recreation, and Community Services at once.