Last Name: _____ School Year: _____ Pocono Mountain School District

Family Emergency Contact Information

To be completed by parent/guardian. Copies held by designated school persons. Grades: _____

Child's Name: _____
Last Name First Name Middle Initial

Child's Mailing Address: _____
Street City State Zip

Mother's/
Guardian's Name: _____
Last Name First Name Middle Initial Employment

Mother's/Guardians
Mailing Address: _____
Street City State Zip

Phone Numbers Cell: _____ Work: _____ Home: _____

Father's/
Guardian's Name: _____
Last Name First Name Middle Initial Employment

Father's/Guardians
Mailing Address: _____
Street City State Zip

Phone Numbers Cell: _____ Work: _____ Home: _____

Driving Directions to reach your home from your child's school:

_____

_____

_____

Who shall be the local contacts if parent/guardian cannot be reached?

Contact Name/Relationship: _____ Contact Phone Number: _____

Contact Name/Relationship: _____ Contact Phone Number: _____

List ALL your children attending Pocono Mountain School District

Child's First & Last Name	Child under medical care (circle yes/no)	Reason	Child has allergies (circle yes/no)	List allergies	Birth date	Grade
	YES or NO		YES or NO			
	YES or NO		YES or NO			
	YES or NO		YES or NO			
	YES or NO		YES or NO			
	YES or NO		YES or NO			

IN CASE OF AN ACCIDENT OR ILLNESS REQUIRING EMERGENCY CARE, I REQUEST THE SCHOOLTO CONTACT ME. IF THE SCHOOL IS UNABLE TO REACH ME IMMEDIATELY, I HEREBY AUTHORIZE THE SCHOOL TO CALL THE PHYSICIAN INDICATED BELOW AND FOLLOW HIS/HER INSTRUCTIONS. IF IT IS IMPOSSIBLE TO CONTACT THE PHYSICIAN IMMEDIATELY, I HEREBY AUTHORIZE THE SCHOOL AUTHORITIES TO MAKE WHATEVER ARRANGEMENTS THAT THEY DEEM NECESSARY UNDER THE CIRCUMSTANCES FOR TREATMENT. IN EMERGENCY SITUATIONS WHEE A STUDENT NEEDS TRANSPORTATION VIA AMBULANCE TO A HOSPITAL, THE STUDENT WILL BE TRANSPORTED TO THE NEAREST HOSPITAL WHITHIN THE AMBULANCE SERVICE AREA.

Family Physician's Name: _____ Family Physician's Phone: _____

Family Physician's Address: _____

Medical Insurance Provider: _____ Dental Insurance Provider: _____

Signature of Parent/Guardian: _____ Date: _____