

**UPPER TOWNSHIP PRIMARY SCHOOL
EMERGENCY FORM**

NAME _____ TEACHER _____

ADDRESS _____ TOWN/ZIP _____

HOME PHONE _____ CELLULAR/BEEPER# MOM: _____
DAD: _____

FATHER'S NAME WORK NUMBER DAYS/HOURS AT THIS #

MOTHER'S NAME WORK NUMBER DAYS/HOURS AT THIS #

**IF I CANNOT BE REACHED PLEASE CONTACT THE FOLLOWING PEOPLE
TO TAKE MY CHILD HOME: (PLEASE USE LOCAL NUMBERS).**

NAME RELATIONSHIP NUMBER

NAME RELATIONSHIP NUMBER

NAME RELATIONSHIP NUMBER

CHECK IF THE STUDENT HAS ANY OF THE FOLLOWING CONDITIONS:

____ HEART CONDITION: ___ RESTRICTIONS NO RESTRICTIONS _____
____ DIABETES ___ ASTHMA ON MEDS _____
____ SEIZURE DISORDER ___ ADVERSE DRUG REACTION/ALLERGIES _____
____ SEVERE ALLERGIES ___ VISION OR HEARING PROBLEM _____
____ GLASSES CONTACTS ___ OTHER _____

**THIS INFORMATION MAY BE SHARED WITH STAFF MEMBERS FOR YOUR CHILD'S PROTECTION
PLEASE EXPLAIN ANY MEDICAL CONDITIONS CHECKED ABOVE**

***YES / NO: THE SCHOOL NURSE HAS MY PERMISSION TO CONTACT MY CHILD'S
PHYSICIAN FOR MEDICAL INFORMATION (Circle yes or no)***

**ALL OVER THE COUNTER AND PRESCRIPTION MEDICATIONS
MUST HAVE A DOCTOR'S ORDER TO BE GIVEN AT SCHOOL.**

DATE _____

(Parent Signature)

PLEASE RETURN THIS FORM IMMEDIATELY.