

ANN ARBOR PUBLIC SCHOOLS
 Parent/Guardian Instructions In Case Of Emergency
 Use Black Ink - Please Print

Student ID #: _____ Forum Leader: _____

Student: _____ / _____ Gender: M _____ F _____ Bus #: _____
Last Name First Name

Student Cell #: _____ Birthdate: _____
 Grade/YOG: _____

Address: _____
Street Apt/Lot # City/Zip Code

Student Home Phone #: _____ Parent Email 1): _____
Mandatory Parent Email 2): _____

Place of Birth (City/State): _____ Student Email: _____

Please list everyone we can call in case of an emergency, illness or school closing and provide their contact information:
 Note: If a parent/guardian is not available, we will call the next person on the list until someone is contacted.

Resides With

<input type="checkbox"/>	1	_____	_____	_____	_____	_____	_____
		Name	Relationship	Employer	Work #	Home #	Cell/Pager
<input type="checkbox"/>	2	_____	_____	_____	_____	_____	_____
		Name	Relationship	Employer	Work #	Home #	Cell/Pager
<input type="checkbox"/>	3	_____	_____	_____	_____	_____	_____
		Name	Relationship	Employer	Work #	Home #	Cell/Pager
<input type="checkbox"/>	4	_____	_____	_____	_____	_____	_____
		Name	Relationship	Employer	Work #	Home #	Cell/Pager

Medical Information

This information will be shared with appropriate school staff.

If the designated parties are not available, I understand appropriate emergency care deemed advisable by school authorities will be sought.
 Any special directions appropriate to my child have been checked below.

Doctor's Name: _____ Doctor's #: _____

Dentist's Name: _____ Dentist's #: _____

Hospital of Choice (UM/St. Joe): _____

Please put an "X" in the appropriate box, specify where indicated, and sign your name

<input type="checkbox"/>	1 Religious objections to physician contact	9 Life threatening allergies (reaction):
		med/drug _____
<input type="checkbox"/>	2 Contact lens/glasses	food _____
		insect _____
<input type="checkbox"/>	3 Bone/joint condition	other _____
<input type="checkbox"/>	4 Diabetes	10 Medications needed/used: _____
<input type="checkbox"/>	5 Heart condition	11 Other conditions/problems: _____
<input type="checkbox"/>	6 Seizure disorder	12 Special blood condition: _____
<input type="checkbox"/>	7 Hypertension or high blood pressure	13 None Known: _____
<input type="checkbox"/>	8 Asthma	

Signature: _____
Parent or Guardian Date