

For Office Use

Grade \_\_\_\_\_

### Emergency Information • North Lakes Academy 2009-2010

Complete both sides of this card to enable NLA to serve your child in the event of an accident, illness, or emergency. PLEASE PRINT.

Student Name \_\_\_\_\_ Birthday \_\_\_\_\_  
Last First Middle Month/Day/Year

Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Street City Zip Area Code/Number

Name of Father \_\_\_\_\_ Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone or Pager \_\_\_\_\_

Name of Mother \_\_\_\_\_ Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone or Pager \_\_\_\_\_

Brothers and/or Sisters (Names and Ages)

Student lives with: \_\_\_\_\_ Both Parents \_\_\_\_\_ Mother Only \_\_\_\_\_ Father Only \_\_\_\_\_ Guardian  
(If Guardian, list name, address, home and work phone numbers below.)

List two neighbors or nearby relatives who can assist if parent or guardian cannot be reached:

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

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Name of Father \_\_\_\_\_ Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone or Pager \_\_\_\_\_

Name of Mother \_\_\_\_\_ Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone or Pager \_\_\_\_\_

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Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_ Phone \_\_\_\_\_

Health Information (list any health conditions -- diabetes, asthma, bee sting allergies, etc.):

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Immunizations received within last year (include dates):

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Family Doctor \_\_\_\_\_ Phone\_(\_\_\_\_\_)\_\_\_\_\_

Family Dentist \_\_\_\_\_ Phone\_(\_\_\_\_\_)\_\_\_\_\_

Hospital Preference \_\_\_\_\_

We, the undersigned, do hereby authorize officials of North Lakes Academy to contact directly the persons named on this card, and do authorize the named physician(s) to render such treatment as may be deemed necessary in an emergency, for the health of said student.

In the event that physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid student.

We acknowledge that we are responsible for all charges in connection with any care and treatment rendered.

\_\_\_\_\_  
Signature of mother or guardian      Date

\_\_\_\_\_  
Signature of father or guardian      Date

**E-mail address(es), for communication purposes in non-emergency situations:**

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Health Information (list any health conditions -- diabetes, asthma, bee sting allergies, etc.):

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Immunizations received within last year (include dates):

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Family Doctor \_\_\_\_\_ Phone\_(\_\_\_\_\_)\_\_\_\_\_

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Signature of mother or guardian      Date

\_\_\_\_\_  
Signature of father or guardian      Date

**E-mail address(es), for communication purposes in non-emergency situations:**

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