



Emergency Contacts
(not in the same household)

Contact 1:

Contact 2:

Name: _____

Name: _____

Relationship to child: _____

Relationship to child: _____

Day Phone: _____

Day Phone: _____

Physician

Child's Physician: _____ Phone: _____

Hospital Preference: _____

Additional Information

Does your child have and fears or medical needs such as medication, allergies, nose bleeds, etc.

Does your child have any known communicable disease, chronic illness (asthma, seizure disorder, visual or hearing problem, etc)? Please describe.

Has your child ever had any serious medical illness (febrile seizures, meningitis, respiratory problems, etc.)? If yes, please describe.

Auto Insurance

(Please list the following information from your policy)

Name of Insured: _____

Insurance Company: _____

Liability: Bodily injury \$ _____ / _____ (per person/accident)

Property damage \$ _____ (per person)

Renewal Date: _____

Agent: (Name) _____ (Phone Number) _____

Note: Parkview students are not to ride in a vehicle's front seat during field trips.