

Broadalbin-Perth Central School District

Emergency Contact Form for After School Activities

Name of Activity: _____

Student Name: _____ Age: _____ Date of Birth ____/____/____

Address: _____

City: _____ State: _____ Zip: _____

Teacher: _____ Grade: _____

Emergency Contact Information

Please list the names of those to be contacted in case of an emergency.
(Should you require more space, please attach to this sheet).

Name: _____ Relationship: _____

Phone: _____ Cell/Alternate: _____

Address: _____

Name: _____ Relationship: _____

Phone: _____ Cell/Alternate: _____

Address: _____

Name: _____ Relationship: _____

Phone: _____ Cell/Alternate: _____

Address: _____

Medical Information

Allergies (to medication and any other allergy):

Medical Conditions/Concerns: _____

Daily Medications:

Drug Name	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____

As needed medications (ex. Inhalers, Epi-Pens) _____

Physician: _____ Phone: _____

Address: _____

Insurance Name: _____ Group # _____

ID# _____

In the event of a medical emergency, I authorize the Broadalbin-Perth Central School District to transport my child _____ to the closest medical facility for necessary treatment and or care.

Signature of Parent/Guardian: X _____ Date: _____