

**Sperry Public Schools**  
Emergency Contact Information

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Birthdate \_\_\_\_\_  
Last First Middle

Mailing Address: \_\_\_\_\_  
Street City State Zip

Physical Address (if different from mailing) \_\_\_\_\_  
Street City State Zip

**Parent/Guardian:**

Name: \_\_\_\_\_ Relationship to child \_\_\_\_\_ Main Phone \_\_\_\_\_  
Mobile Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child \_\_\_\_\_ Main Phone \_\_\_\_\_  
Mobile Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_ Insurance: \_\_\_\_\_

List anyone authorized to pick up your child in case of illness or injury and you cannot be reached at the above numbers.  
**Only those persons listed will be authorized to pick up your child without additional approval from you.**

Name: \_\_\_\_\_ Relationship to child \_\_\_\_\_ Main Phone \_\_\_\_\_  
Mobile Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to child \_\_\_\_\_ Main Phone \_\_\_\_\_  
Mobile Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Does your child have any serious allergies? Yes / No (If yes, please explain) \_\_\_\_\_

Has your child had any serious childhood illnesses or accidents? Yes / No (If yes, please explain) \_\_\_\_\_

Has your child had any surgeries? Yes / No (If yes, please list) \_\_\_\_\_

Does your child have any specific medical problems or physical limitations that we should know about?  
Yes / No (If yes, please explain) \_\_\_\_\_

Topical and/or first aid items may be utilized by school personnel unless there is a specific objection by the  
parent/guardian. Please list any topical or first aid items that are NOT to be used. \_\_\_\_\_

**Administration of all prescription medication or non-prescription medication will require a separate authorization form that may be obtained from the secretary of the building your child is attending. Any additional medication or changes made during the school year will require a new form.**

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I understand that in the event of an emergency, every effort will be made to contact me. In the event that I cannot be reached, I hereby authorize any physician, surgeon, dentist, or the medical staff at the nearest medical facility to administer any emergency treatment, procedure, or medicine necessary and advisable. I also authorize the use of an ambulance, if necessary, to transport my child. I further agree to pay for all services provided for my child. If this is not satisfactory, please list specific emergency instructions in the event that you cannot be reached: \_\_\_\_\_

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Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_