

Fort Bend ISD
 Emergency Contact Form
 Fine Arts Department



PLEASE PRINT

Student's Name: _____ Campus: _____
Last First Middle

Age: _____ Date of Birth: _____/_____/_____ Grade: _____ Gender: M F Student ID#: _____

Address: _____

City: _____ Zip: _____ Home Phone Number: (_____) _____ - _____

Name of Physician: _____ Physician's Telephone: (_____) _____ - _____

Allergies:

Yes No List: _____

Current Medications:

Yes No List: _____

Medical Health Insurance Coverage:

Yes No

Insurer: _____ Group #: _____ ID #: _____ Phone #: _____

Parent/Guardian 1 Work #: _____ Parent/Guardian 1 Cell #: _____

Place of Employment: _____ Email Address: _____

Parent/Guardian 2 Work #: _____ Parent/Guardian 2 Cell #: _____

Place of Employment: _____ Email Address: _____

Medical History:

	Yes	No		Yes	No
Allergies to medication	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding tendencies	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease and/or injury	<input type="checkbox"/>	<input type="checkbox"/>
Bone and/or joint injury or disease	<input type="checkbox"/>	<input type="checkbox"/>	Neck injury	<input type="checkbox"/>	<input type="checkbox"/>
Contact Lenses/Glasses/Vision impairment	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Eye, Kidney, Lung removed/nonfunctioning	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Head injury, concussion, loss of consciousness	<input type="checkbox"/>	<input type="checkbox"/>	Skin Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart-Related illness	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Hospitalizations in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	Is student currently under a physician's care?	<input type="checkbox"/>	<input type="checkbox"/>

Explain all "Yes" answers here: _____
 (Attach another sheet if necessary)

Date of your last tetanus shot: _____

Parent/Guardian Permit Waiver:

If, in the judgement of any representative of the schools, the said student should need immediate care and treatment as a result of an injury or sickness, I do hereby request, authorize, and consent to such care and treatment as may be given said student by any physician, athletic trainer, nurse, or school representative, and I do hereby agree to indemnify and save harmless the school and any school representative from any claim by any person whomever on account of such care and treatment of said student.

Parent/Guardian Name (Printed): _____

Parent/Guardian Signature: _____ Date: _____

Please return this form to your child's teacher of record.

This form must accompany the student on all school trips.