

# WESTERLY LEARNING CENTER

## EMERGENCY MEDICAL INFORMATION

**STUDENT NAME:** \_\_\_\_\_ Birth date: \_\_\_\_\_  
Street Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Home Phone ( ) \_\_\_\_\_ Social Security Number \_\_\_\_\_

**FATHER'S NAME:** \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
Employer (Name and Address): \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_ Beeper: ( ) \_\_\_\_\_

**MOTHER'S NAME:** \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_  
Employer (Name and Address): \_\_\_\_\_  
Work Phone: ( ) \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_  
E-Mail Address: \_\_\_\_\_ Beeper: ( ) \_\_\_\_\_

### ADDITIONAL EMERGENCY CONTACTS

Name: \_\_\_\_\_ Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Phone: ( ) \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

### HEALTH INSURANCE COVERAGE

Insurance Company Name: \_\_\_\_\_  
Insurance Company Phone Number: \_\_\_\_\_  
Cardholder's Name \_\_\_\_\_ Employer: \_\_\_\_\_  
Group Number \_\_\_\_\_ Individual I.D. \_\_\_\_\_

**PHYSICIAN:** \_\_\_\_\_  
Address \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**DENTIST:** \_\_\_\_\_  
Address \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

**PREFERRED HOSPITAL:** \_\_\_\_\_  
Address \_\_\_\_\_ Phone: ( ) \_\_\_\_\_

### ADDITIONAL INFORMATION

Allergies to food/medicine: \_\_\_\_\_

Additional medical conditions (including the wearing of eyeglasses or hearing aides):  
\_\_\_\_\_  
\_\_\_\_\_

*I hereby give permission to the administrators of Westerly Learning Center, or the teacher in charge, to arrange for my child to receive medical attention in the event of an emergency. I recognize that every effort will be made to contact me and/or the emergency contact person(s) named above.*

**PARENT(S) SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_