Translated versions of this document are available at: www.philasd.org/translation (search word "EH-4")

(EH-4)

SCHOOL DISTRICT OF PHILADELPHIA
EMERGENCY CONTACT FORM

Sex	Grade	Rm./Sec./Bk.

Student ID	Student's Name	Birth Date	School No.

Address	Zip Code	Apt. No.	Home Phone

Enter Child's Social Security No.	Does your child have health insurance? ☐ Yes ☐ No If Yes, check the appropriate health insurance below:
Name of child's doctor/clinic / Phone No.	☐ Aetna/US Health Care ☐ Health Partners ☐ Keystone Mercy ☐ Other ☐ Blue Cross ☐ Americhoice ☐ Keystone Health Plan East
Name of child's dentist/clinic / Phone No.	

First Emergency Contact (fu ll name) Parent/Guardian	Relationshi p to child	Daytime Phone	Cell Phone	E-Mail
Second Emer gency Contact (full name)				
Third Emergency Contact (full name)				

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Please note

1. **Does your daughter/son have any health needs or problems the school should know?**

   Yes _____ No_____

   If **YES**, please describe

_____

_____

2. **Does your daughter/son take any medication? Yes _____ No_____**

   If **YES**, please describe

_____

_____

3. **Does your daughter/son need to take medication *at school*? Yes _____ No_____**

   If **YES**, please describe

_____

_____