GROWING TOGETHER
— BEHAVIORAL CENTER —

Emergency Information and Contacts

Date Completed: _____

Student's Name:_____

Nickname:_____

DOB:_____ Height: _____ Weight:_____
Diagnosis:_____

Allergies:

Other Medical Concerns:

Medications (name, dose and times):

Significant Behaviors:

Self-Preservation Skills:

Primary Emergency Contacts:

Parent's Name:_____
Home Phone: _____
Daytime Phone: _____
Cell Phone: _____
Email: _____

Parent's Name:_____
Home Phone: _____
Daytime Phone: _____
Cell Phone: _____
Email: _____

Doctor's Name:_____

Office Phone: _____

Additional Emergency Contact

Name Phone Pickup (Y/N)

_____

_____

Others who can pickup student:

_____

_____

_____