



Carbon County School District #2 Adult Emergency & Health Information

Date: _____

Name: _____ DOB: _____

Mailing Address: _____ City: _____ ZIP: _____

Physical Address: _____ City: _____ ZIP: _____

	Primary Emergency Contact	Secondary Emergency Contact
Name:	_____	_____
Home Phone:	_____	_____
Work Phone:	_____	_____
Cell Phone:	_____	_____

Insurance Information

Health Insurance Company: _____

Insured Name: _____

Policy#: _____

Medical / Medication Information

Family Doctor: _____

Doctor's Phone: _____

Hospital Preference: _____

Medications / Supplements Information

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Name: _____ Dosage: _____

Medication conditions: _____

Special instructions in case of emergency: _____

If both of the above emergency contact people cannot be reached, I give my permission for the school to make the decisions as to my immediate care.

Signature: _____ Date: _____

This adult emergency & health information shall stay in effect until changes are made in writing.