

ACCIDENT FORM

Form HD-9-09

WARWICK PUBLIC SCHOOLS
Special Services

SCHOOL _____

DATE _____

Name of Student _____ Date of Birth _____ Grade _____
Last First Middle

ADDRESS _____ PHONE _____ CELL/PAGER _____
Street City Zip

PARENT/GUARDIAN EMPLOYER _____
MOTHER'S NAME WORK PHONE _____
CELL/PAGER _____

FATHER'S NAME EMPLOYER _____
WORK PHONE _____
CELL/PAGER _____

EMAIL ADDRESS - HOME _____
WORK _____

EMERGENCY CONTACTS

In case of minor illness requiring that student be sent home and parents are not available please indicate the names of relatives or friends who would assume responsibility.

NAME _____ RELATIONSHIP _____ PHONE _____

NAME _____ RELATIONSHIP _____ PHONE _____

CONTINUED ON REVERSE SIDE

VISION/HEARING CONDITIONS? _____

Are there any medical conditions? Yes _____ No _____

Describe any medical conditions/allergies: _____

Does student take any medication? Yes _____ No _____

Pediatrician _____ Phone _____

If medical attention is needed and the parent cannot be reached, the school will contact 911 and the pupil will be taken to the appropriate hospital.

The School Nurse/Teacher has my permission to contact my child's pediatrician/Doctor for further information or questions regarding my child's health.

This information may be shared with school personnel on an as needed basis.

SIGNATURE OF PARENT OR GUARDIAN