SOUTHERN WESTCHESTER BOCES
BOARD OF COOPERATIVE EDUCATIONAL SERVICES

EMERGENCY CONTACT INFORMATION - CENTER FOR SPECIAL SERVICES

STUDENT NAME:_____ DOB: _____ TODAY'S DATE: _____

ADDRESS:_____

NAME OF PARENT/GUARDIAN: (PRINT CLEARLY)

P/G: ( )_____	P/G: ( )_____
HOME PHONE: ( )_____	HOME PHONE: ( )_____
BUSINESS PHONE: ( )_____	BUSINESS PHONE: ( )_____
MOBILE PHONE: ( )_____	MOBILE PHONE: ( )_____
EMAIL: _____	EMAIL: _____
RELATIONSHIP TO STUDENT:_____	RELATIONSHIP TO STUDENT:_____

EMERGENCY CONTACTS*: (***MUST*** BE ABLE TO PICK UP OR RECEIVE ***SICK*** CHILD)

NAME:_____ RELATIONSHIP:_____ PHONE: _____

NAME:_____ RELATIONSHIP:_____ PHONE: _____

NAME:_____ RELATIONSHIP:_____ PHONE: _____

** Duplicate Numbers Not Acceptable*

FAMILY PHYSICIAN: _____

ADDRESS: _____ PHONE: ( )_____

MEDICAL ALERTS:

NONE:_____ CARDIAC:_____

DIABETES:_____ ASTHMA:_____

SEIZURES:_____ OTHER:_____

ALLERGIES:

FOOD:_____

DRUG:_____

OTHER:_____

MEDICATIONS: (IF YOUR CHILD TAKES ***MEDICATION***, PLEASE COMPLETE INFORMATION BELOW)

NAME OF MEDICATION	DOSAGE	WHERE TAKEN (***PLACE*** AN ***X***)			
		HOME		SCHOOL	
		HOME		SCHOOL	
		HOME		SCHOOL	
		HOME		SCHOOL	
		HOME		SCHOOL	
		HOME		SCHOOL	

Original to School Nurse, CC: Student File, BOCES Teacher, Accounting - RLC