



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	
		HOME		SCHOOL	