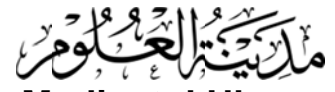


EMERGENCY CARE INFORMATION

In case of an emergency, the school staff will contact 911. Every attempt will be made to contact a parent, a guardian, or a designated emergency contact.



Madinatul Uloom

THE CITY OF KNOWLEDGE

STUDENT INFORMATION & PARENT/GUARDIAN CONTACT INFORMATION

Child's Name	Date of Birth	M	F
		Gender	
Parent's/Guardian's Name	Parent's/Guardian's Name		
()	()		
Home Phone	Home Phone		Work Phone
Address	Address		
City, ST ZIP Code	City, ST ZIP Code		

ALTERNATIVE EMERGENCY CONTACTS

Primary Emergency Contact	Secondary Emergency Contact
()	()
Home Phone	Home Phone
Work Phone	Work Phone
Address	Address
City, ST ZIP Code	City, ST ZIP Code

CURRENT HEALTH CONDITIONS

Below check any current health condition that may require attention During the school day.

- | | |
|---|---|
| <input type="checkbox"/> Allergies (be specific) _____
<input type="checkbox"/> foods _____
<input type="checkbox"/> medicines _____
<input type="checkbox"/> bee sting or insect bite _____
<input type="checkbox"/> other _____ | <input type="checkbox"/> hemophilia
<input type="checkbox"/> heart problems (be specific) _____
<input type="checkbox"/> physical disability (be specific) _____
<input type="checkbox"/> respiratory (be specific) _____
<input type="checkbox"/> seizures
<input type="checkbox"/> vision problems (be specific) _____
<input type="checkbox"/> glasses <input type="checkbox"/> contacts
<input type="checkbox"/> other (be specific) _____ |
| <input type="checkbox"/> asthma
<input type="checkbox"/> cancer
<input type="checkbox"/> diabetes
<input type="checkbox"/> hearing problems <input type="checkbox"/> hearing aid(s) | |

List all medications and dosages your child receives on a continual basis: _____

PHYSICIAN INFORMATION

Hospital/Clinic Preference	
Physician's Name	Phone Number
Insurance Company	Policy Number

The school has my permission, in an emergency when I cannot be contacted, to take my child to the nearest appropriate medical facility, and the facility and its medical staff have my authorization to provide treatment that a physician deems necessary for the well-being of my child.

Parent's/Guardian's Signature	Date
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