



Cypress-Fairbanks I.S.D. SUBSTITUTE EMERGENCY CARE FORM

This information will be kept on file as confidential and referred to only in the event you become ill or injured while on a campus.

PLEASE PRINT LEGIBLY:

NAME: _____ DATE OF BIRTH: _____
Last First

ADDRESS: _____
Street City Zip

TELEPHONE: _____
Home Cell

NEAREST RELATIVE/FRIEND: (Persons to notify in case of emergency)

1. _____
Name Relationship Telephone
2. _____
Name Relationship Telephone
3. _____
Name Relationship Telephone

PLEASE COMPLETE THE FOLLOWING IN CASE OF ILLNESS OR ACCIDENT:

Doctor's Name _____

Telephone _____

Hospital Preference _____

Medication _____

Known Medication _____

Other Medical Conditions _____

(Please note any other significant information in the event of illness or accident (contact lenses, dentures, pacemaker, etc.)