EMERGENCY MEDICAL PLAN FOR BUS RIDERS

Student _____ Date of birth _____

Diagnosis or Problem _____

Contact Information

Father's Name _____ Phone _____

Address _____ Work/Cell _____

Mother's Name _____ Phone _____

Address _____ Work/Cell _____

Student resides with _____

Additional Emergency Contacts _____

Student's Physician _____ Phone _____

PLAN

If you see this	Do this
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

My child is allergic to _____

Additional Information _____

_____

_____

Parents give permission to transport my student to nearest hospital and assume all responsibility, financial and other.

Parent/Guardian Signature _____ Date _____