Impact Emergency Form

Student's Name:_____ Birthdate:_____

Student's Name:_____ Birthdate:_____

Parent / Guardian (Person to contact in case of emergency)

Name:_____

Address:_____

Cell Phone:_____ Work Phone:_____

Name:_____

Address:_____

Cell Phone:_____ Work Phone:_____

Alternate Person (In case parent/guardian cannot be reached)*

Name:_____

Address:_____

Cell Phone:_____ Work Phone:_____

Name:_____

Address:_____

Cell Phone:_____ Work Phone:_____

* In the event of a medical emergency, our primary goal is the safety and well-being of your child. Our staff is trained in first aid and CPR and is prepared to respond quickly and effectively to any situation. You give consent for Impact staff to seek and approve emergency medical care if you or emergency contacts cannot be reached.

Hospital Preference_____

Insurance Company_____

Policy holder's name_____

Policy number_____

_____ _____

Parent / Guardian Signature **Date**