

**Dominion School for Autism-Student Emergency Information
Summer 2008 and School Year 2008-2009**

Student's Full Name: _____	SSN: _____	
Date of Birth: _____	Diagnosis/Identification: _____	
Address: _____ _____		
Parent/Guardian Name: _____		
Home Phone: _____	Work Phone: _____	Cell Phone: _____
Parent/Guardian Name: _____		
Home Phone: _____	Work Phone: _____	Cell Phone: _____
Emergency Contact: _____	Relationship: _____	
Home Phone: _____	Work Phone: _____	Cell Phone: _____
Emergency Contact: _____	Relationship: _____	
Home Phone: _____	Work Phone: _____	Cell Phone: _____
Names of Person(s) other than parents/guardians who are authorized to pick up child: _____ _____		

Please list <u>all</u> medications taken by the student, including those not taken at school, dosages, times of administration and purpose for which medications are given: _____ _____

Physician's Name: _____	Phone: _____	
Does the child currently have any of the following: (if yes, please circle and describe below)		
Asthma	Food Allergies	Special Dietary Needs
Dizziness	Drug Allergies	Frequent Headaches
Seizures	Allergy to Insect Bites	Other Medical Conditions
	Allergy to Bee Stings	
Please Describe: _____		