

**Hawaii School for the Deaf and the Blind**  
Emergency Information Form

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Sex: M / F

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ Other Phone: \_\_\_\_\_

In case of illness or injury and the person listed above cannot be reached, the school authorities have my permission to contact the following people listed below:

Name	Relationship	Phone Number

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Hospital Preferred: \_\_\_\_\_ Medical Coverage: \_\_\_\_\_

Medical condition, allergy or problem the school should know of: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Restrictions or special conditions needed in school. (Please attach doctor's note): \_\_\_\_\_

\_\_\_\_\_

Medication found on my person or in my belongings:

Medication \_\_\_\_\_ Dose \_\_\_\_\_ How often? \_\_\_\_\_

Medication \_\_\_\_\_ Dose \_\_\_\_\_ How often? \_\_\_\_\_

To assure that we can provide you with prompt and accurate assistance, it is necessary to have all information current. **PLEASE NOTIFY OUR OFFICE OF ANY CHANGES.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_