Vista Learning Center
an RSEC program

EMERGENCY INFORMATION

Student's Full Name: _____ DOB: _____

Is student covered by any hospitalization/medical care policy? ☐ Yes ☐ No

Insurance Company's Name: _____
Address: _____
Policy and Identification Number: _____

Name of Student's Primary Care Physician: _____
Location: _____ Phone Number: _____

Name of Student's Dentist: _____
Location: _____ Phone Number: _____

Other Physicians/Counselors/Psychiatrists student is currently under the care of:
Name: _____ Phone Number: _____
Reason: _____

Name: _____ Phone Number: _____
Reason: _____

Emergency Contacts

In the event that parent/guardian(s) is unable to be reached, please list 2 people whom you designate to assume responsibility for your student's health care in an emergency or non-emergency:
Name: _____ Relationship: _____
Contact Number #1: _____ Contact Number #2: _____
1. Name: _____ Relationship: _____
   Contact Number #1: _____ Contact Number #2: _____

In the event that I/we cannot be reached, I/we authorize Vista Learning Center, its agents, employees, or other officers to procure and consent to any medical examination, anesthesia, operation, emergency transportation, hospital care, or other necessary treatment, to be rendered to my/our child by or under the supervision of any duly licensed health care provider.

A copy of this authorization is to be accepted as valid as the original.

_____ _____
Parent/Guardian Signature Date

_____ _____
Parent/Guardian Signature Date