IVYMOUNT
OUTREACH PROGRAMS

Student Emergency Contact & Information Sheet

Student Name:_____ **Date of Birth**:_____

Primary contact in case of emergency:

1. _____ Phone: _____

Alternate contact in case of emergency:

1. _____ Phone: _____

Other contacts in case of emergency:

1. _____ Phone: _____
2. _____ Phone: _____

Primary Physician: _____ Phone: _____

1. Does your child take any medications? _____
   _____
   _____
   _____
2. Which medications are given at home? _____
   _____
   _____
   _____
3. Does your child have any allergies? **Y / N** To what? _____
   _____
   _____
   _____
   Explain allergic reaction _____
4. Does your child have a seizure disorder? **Y/N** If so, please describe in detail what your child's seizures look like, whether he or she is on medication for seizures, and specific details in how you handle your child's seizures._____
   _____
   _____
   _____
   _____
   _____
   _____
5. Is your child on a special diet? **Y / N** If so, what are the special instructions? _____
   _____
   _____
   _____
   _____

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6. Has your child ever been stung by a bee? **Y / N** Was there an unusual reaction? **Y / N**

7. Any additional medical information we should know? _____
_____
_____
_____

8. Is there any special information we need if your child has to go to the emergency room?
_____
_____

9. What are your child's likes? _____
_____
_____
_____

10. What are your child's dislikes? _____
_____
_____
_____

11. What items does your child find reinforcing? (ex: stress balls, small toys, iPad, etc.)
_____
_____
_____
_____

12. What does your child find aversive? (ex: loud noises, music, bright lights, etc.)
_____
_____
_____
_____

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