



## 2018-2019 FBCMI Academy Student Emergency File

Name of Child: \_\_\_\_\_ Date of Birth \_\_\_\_\_

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

Name of Parent or Guardian: \_\_\_\_\_

### In Case of Emergency Contact:

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Name	Relationship	Cell
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Name	Relationship	Cell
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### Physician's Information:

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Name	Phone
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### Dentist's Information:

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Name	Phone
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Should your child suffer from a serious injury and needs to be transported by Emergency Medical Personnel to the nearest hospital, do you give your permission for such transport and agree to pay for the expenses incurred?

\_\_\_\_ Yes \_\_\_\_ No

If No, please explain: \_\_\_\_\_

**\*\*\*Known allergies, asthma, diabetes, epilepsy etc. or special condition\*\*\***

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I certify that to the best of my knowledge \_\_\_\_\_ is in good mental and physical health to participate in FBCMI Academy.

**Parent Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_