

**OCEAN ACADEMY
STUDENT EMERGENCY UPDATE SHEET**

STUDENT NAME: _____ DOB: _____

ADDRESS: _____ S.S.# _____

_____ HOME PHONE #: _____

PARENT/GUARDIAN: _____ CELL #: _____

EMAIL ADDRESS: _____

EMPLOYER: _____ WORK #: _____

EMPLOYER ADDRESS: _____

INSURANCE CO: _____ ID# _____

CARD HOLDER'S NAME _____ DOB: _____

CARD HOLDER'S SS# _____

HEALTH PROBLEMS/MEDICATIONS

CHRONIC HEALTH ISSUES: _____

PRESENT MEDICATION(S): _____

MEDICATION ALLERGIES OR OTHER ALLERGIES: _____

EMERGENCY CONTACT PEOPLE

1) NAME: _____ 2) NAME: _____

RELATIONSHIP: _____ RELATIONSHIP: _____

ADDRESS: _____ ADDRESS: _____

PHONE #: _____ PHONE #: _____

CELL #: _____ CELL #: _____

PHYSICIAN INFORMATION

FAMILY PHYSICIAN OR CLINIC USED: NAME: _____

ADDRESS: _____ PHONE #: _____

PSYCHIATRIST: _____ PHONE #: _____

SIGNATURE: _____ **DATE** _____

NO PRESCRIPTION MEDICATIONS WILL BE DISPENSED IN THE SCHOOL WITHOUT SPECIFIC WRITTEN INSTRUCTIONS FROM YOUR PHYSICIAN.

PLEASE REFER TO OCEAN ACADEMY HANDBOOK.