

SCHOOL DISTRICT OF PHILADELPHIA EMERGENCY CONTACT FORM					Sex	Grade	Rm./Sec./Bk.
(EH-4)	Student ID	Student's Name			Birth Date		School No.
Address			Zip Code	Apt. No.	Home Phone		
Enter Child's Social Security No.				Does your child have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, check the appropriate health insurance below:			
Name of child's doctor/clinic			Phone No.		<input type="checkbox"/> Aetna/US Health Care		<input type="checkbox"/> Blue Cross
Name of child's dentist/clinic			Phone No.		<input type="checkbox"/> Health Partners		<input type="checkbox"/> Americhoice
					<input type="checkbox"/> Keystone Mercy		<input type="checkbox"/> Keystone Health Plan East
					<input type="checkbox"/> Other		
First Emergency Contact (full name) Parent/Guardian		Relationship to child	Daytime Phone	Cell Phone	E-Mail		
Second Emergency Contact (full name)							
Third Emergency Contact (full name)							

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