

SCHOOL DISTRICT OF PHILADELPHIA  
**EMERGENCY CONTACT FORM**

		Sex	Grade	Rm.-Sec.-Bk.
Student ID	Student's Name		Birth Date	School No.
Address		Apt. No.	Home Phone	
Enter Child's Pennsylvania I.D. Number		Does your child have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Child's Doctor/Clinic		If Yes, check the appropriate health insurance below:		
Name of Child's Dentist/Clinic		<input type="checkbox"/> Aetna/US Health Care <input type="checkbox"/> Blue Cross <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 - 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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