THE LOWELL SCHOOL
EMERGENCY CONTACT INFORMATION
SCHOOL YEAR 2024 - 2025

Student's Name: _____ _____ _____
LAST FIRST DATE OF BIRTH

Home Address: _____ _____ _____ _____
STREET CITY ZIP HOME PHONE #

MOTHER'S Name: _____ _____ _____
LAST FIRST CELL PHONE #

Home Address: _____ _____ _____ _____
STREET CITY ZIP HOME PHONE #

Work Address: _____ _____ _____ _____
STREET CITY ZIP WORK PHONE #

Email Address: _____

FATHER'S Name: _____ _____ _____
LAST FIRST CELL PHONE #

Home Address: _____ _____ _____ _____
STREET CITY ZIP HOME PHONE #

Work Address: _____ _____ _____ _____
STREET CITY ZIP WORK PHONE #

Email Address: _____

EMERGENCY CONTACTS: (3 neighbors or nearby relatives who can be contacted in an emergency**)**

_____ _____ _____ _____
LAST NAME FIRST NAME RELATIONSHIP TO CHILD CELL #

_____ _____ _____ _____
LAST NAME FIRST NAME RELATIONSHIP TO CHILD CELL #

_____ _____ _____ _____
LAST NAME FIRST NAME RELATIONSHIP TO CHILD CELL #

THE FOLLOWING MEDICATION(S) MAY BE ADMINISTERED TO MY CHILD:
_____Tylenol _____ Benadryl _____ Tums

MY CHILD IS ALLERGIC TO THE FOLLOWING:

_____

_____

LOCAL DOCTOR:

_____ _____ _____
LAST NAME FIRST NAME OFFICE PHONE #

_____ _____ _____
STREET CITY ZIP

In case of an accident or serious illness, I request the school to contact me. If the school is unable to reach me or my emergency contacts, I authorize the school to call the physician listed above. If it is impossible to contact anyone, the school may make any arrangements deemed necessary.

_____ _____
Parent/Guardian Signature Date