**Josephine Scala, Business Teacher**

**EMERGENCY CONTACT FORM**

Dear Parent or Guardian:

If it becomes necessary to contact you concerning your child’s Work-Based Learning experience, important school information or any emergency situation that might arise, we are requiring a completed copy of this **Emergency Contact Form** be on file at The Tech Center. Please complete this information and have your child return it to their teacher along with completed copy of the **Student Training Plan**.

Thank you for your support of our Tech related Work Based Learning Experience.

Josephine Scala, Business Teacher

**EMERGENCY CONTACT INFORMATION**

Student’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home School: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete Home Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student’s Medicaid Number: \_\_\_\_\_\_\_\_\_\_\_\_\_ or Health Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Conditions (allergies, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medications taken regularly: \_\_\_

**ADDITIONAL EMERGENCY CONTACT:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_ Daytime Phone

Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_