Wagner College Department for Lifelong Learning
Emergency Contact Information

Please fill out the following information to the best of your knowledge.

Child's Name _____, _____ Date of Birth _____/____/_____
(Last Name) (First Name) Month Day Year

Gender M or F (Please circle) Home Phone (____)_____

Home Address _____
Street City State Zip Code

Parent/Guardian Name _____, _____
(Last Name) (First Name)

Cell Phone (____)_____

Emergency Contact (In case parent/guardian cannot be reached)

_____, _____
(Last Name) (First Name)

Home Phone (___)_____ Cell Phone: (___)_____

Allergies (Please indicate if child has any allergies diagnosed by his/her physician)

_____

Medication Currently Prescribed **Yes** or **No**
If **yes**, please list: _____

Other preexisting health conditions that should be monitored

_____

_____

Additional needs or situations that instructor(s) and administration should be aware of

_____

_____

Primary Care Physician _____ Phone (___)_____Date of last exam _____

Special instructions when seeking emergency medical care:

_____

_____

I have informed Wagner College of all my child's known health conditions. In emergencies requiring immediate medical attention, your child will be taken to the nearest hospital emergency room. Your signature authorizes evaluation and treatment by our health care providers at The Wagner College Center for Health and Wellness, local urgent care, and/or local hospital emergency department for necessary medical care to be administered.

Signed: _____Print Name: _____Date: _____