Rose Urban Rural Exchange

TEACHER EMERGENCY INFORMATION

First name	Middle	Last	Birthdate

NAME OF PHYSICIAN: _____

Physician's Phone Number: _____

Chronic illness, disease, or condition (asthma, diabetes, etc.)

_____

_____

Allergies: **Reaction:** **(rash, breathing problems, etc.)**

To food _____

To medication _____

Other allergies _____

I am taking the following prescription medication(s): _____

_____

I agree to have in force the following medical insurance plans:

Name of health insurance carrier _____

Insured Party _____

Policy Number _____