# THERAPY PROS O.T. & EDUCATIONAL SERVICES, PLLC
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**Staten Island, New York 10314**
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## STUDENT HEALTH AND EMERGENCY INFORMATION FORM

Student name_____ Grade_____
Last First Middle (full middle name)

Address_____
No. Street Town Zip code

Home Phone: _____Gender: _____Date of Birth:_____

Language spoken at home: _____Place of Birth_____

Parent/Guardian name (printed): _____

Home
Address_____

Home Phone: _____Work Phone: _____

Cell Phone: _____ E-Mail Address: _____

**IN CASE OF EMERGENCY AND NEITHER PARENT CAN BE REACHED, PLEASE LIST NAME AND PHONE NUMBER OF RELATIVE OR FRIEND WE MAY CONTACT.**

EMERGENCY NAME_____Relationship_____

Home Phone: _____Work Phone: _____Cell Phone: _____

Physician's
Name_____Phone_____

Please check all that applies to your child:
Heart
condition____Diabetes____Asthma____SeizureDisorder____ADD/ADHD____Migraines__Depression____

Medications/Other_____

Allergies (food, insects medication, environment, (specify): _____

Does your child have and EpiPen? Yes: _____No: _____

Parent/Guardian
Signature_____Date_____