

Cobb County Public Schools
CLINIC CARD

Please print in ink

Grade _____ Teacher _____ School and Year _____

Name _____ M ___ F ___ DOB _____
Last First Middle

Address _____ Home Phone _____
Street City Zip

Names of parents/guardians with whom student resides (legal custody):

Name Relationship Work Phone Cell Phone/Pager Daytime Phone

Name Relationship Work Phone Cell Phone/Pager Daytime Phone

Names of siblings: _____ School attends _____ DOB _____
_____ School attends _____ DOB _____

Health Problems: _____ Allergies: Yes / No List here: _____

List All Routine Medications: _____

EMERGENCY CONTACT: (other than parent/guardian) - PLEASE USE LOCAL CONTACTS ONLY

These persons will assume temporary care of your child in the event you cannot be reached.

1. _____
Name Relationship Work Phone Cell Phone/Pager Daytime Phone

2. _____
Name Relationship Work Phone Cell Phone/Pager Daytime Phone

***MEDICAL RELEASE STATEMENT:** I hereby authorize Cobb County Schools to seek emergency medical assistance for my child in the event the parent or guardian cannot be reached. I will assume full responsibility for all charges related to above.

Parent/guardian Signature _____ Date _____

Cobb County Public Schools
CLINIC CARD

Please print in ink

Grade _____ Teacher _____ School and Year _____

Name _____ M ___ F ___ DOB _____
Last First Middle

Address _____ Home Phone _____
Street City Zip

Names of parents/guardians with whom student resides (legal custody):

Name Relationship Work Phone Cell Phone/Pager Daytime Phone

Name Relationship Work Phone Cell Phone/Pager Daytime Phone

Names of siblings: _____ School attends _____ DOB _____
_____ School attends _____ DOB _____

Health Problems: _____ Allergies: Yes / No List here: _____

List All Routine Medications: _____

EMERGENCY CONTACT: (other than parent/guardian) - PLEASE USE LOCAL CONTACTS ONLY

These persons will assume temporary care of your child in the event you cannot be reached.

1. _____
Name Relationship Work Phone Cell Phone/Pager Daytime Phone

2. _____
Name Relationship Work Phone Cell Phone/Pager Daytime Phone

***MEDICAL RELEASE STATEMENT:** I hereby authorize Cobb County Schools to seek emergency medical assistance for my child in the event the parent or guardian cannot be reached. I will assume full responsibility for all charges related to above.

Parent/guardian Signature _____ Date _____

