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(EH-4) SCHOOL DISTRICT OF PHILADELPHIA EMERGENCY CONTACT FORM				Sex	Grade	Rm./Sec./Bk.
Student ID	Student's Name			Birth Date		School No.
Address			Zip Code	Apt. No.	Home Phone	
Enter Child's Social Security No.			Does your child have health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, check the appropriate health insurance below:			
Name of child's doctor/clinic		Phone No.		<input type="checkbox"/> Aetna/US Health Care	<input type="checkbox"/> Blue Cross	
Name of child's dentist/clinic		Phone No.		<input type="checkbox"/> Health Partners	<input type="checkbox"/> Americhoice	
				<input type="checkbox"/> Keystone Mercy	<input type="checkbox"/> Keystone Health Plan East	
				<input type="checkbox"/> Other		
First Emergency Contact (full name) Parent/Guardian		Relationship to child	Daytime Phone	Cell Phone	E-Mail	
Second Emergency Contact (full name)						
Third Emergency Contact (full name)						

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