Department of Public Safety Standards and Training
Student Emergency Data Sheet

Student Contact Information

Name: _____ DOB: _____ Age: _____
DPSST#: _____ Class#: _____
Address: _____
Phone: (Home)_____ (Work)_____ (Message)_____

Agency Contact Information

Agency: _____ Phone: _____
Address: _____
Supervisor: _____ Cell Phone: _____
Supervisor Email: _____
Immediate First Line of Contact (if different than above):
Name: _____ Cell Phone: _____

Emergency Contact Information

Physicians Name: _____ Phone: _____
Primary Emergency Contact: _____
Relationship: _____ Phone: _____
Secondary Emergency Contact: _____
Relationship: _____ Phone: _____

Student Medical Information

Prior Medical Issues: ☐ No ☐ Yes (if yes, explain)

_____
_____
_____

Are you currently taking any medications? ☐ No ☐ Yes (if yes, explain)

_____
_____
_____

Do you have any allergies to medications? No ☐ Yes (if yes, explain)

_____
_____
_____

Have you ever suffered a concussion? ☐ No ☐ Yes (if yes, explain)

_____
_____
_____