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 (Your first point of contact for any training issues):

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)