

**Department of Public Safety Standards and Training**  
**Student Emergency Data Sheet**



**Student Contact Information**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
DPSST# \_\_\_\_\_ Class# \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Mobile) \_\_\_\_\_  
Email: (Personal) \_\_\_\_\_

**Agency Contact Information**

Agency: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
Designated Agency Contact (list rank): \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

**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)