EMERGENCY INFORMATION

SECTION 1: GENERAL INFORMATION

TEACHER: **ROOM:**

Student name: Last First Middle

Student birth date: Male Female

Student lives with: **Home telephone number:**

Student address: Street City State Zip

If Catholic, parish affiliation:

In case of illness or emergency, who should be contacted first:

Mother/Guardian :

Last name First name

Home address: Street City State Zip

Place of employment: Employer Street City State Zip

Phone numbers: Home Work Mobile

E-mail: Home Work

Father/Guardian :

Last name First name

Home address: Street City State Zip

Place of employment: Employer Street City State Zip

Phone numbers: Home Work Mobile

E-mail: Home Work

(If your child is picked up after school by a day care center or a permanent babysitter, please indicate this information below.)

Name of child care person/center:

Address: Street City State Zip **Phone:**

SECTION II: PERSONS AUTHORIZED TO PICK UP CHILD (INCLUDING PARENTS/GUARDIAN)

(Under no circumstances will the child be release to anyone not known to the school without written authorization from the parents/legal guardian.)

Name: Last First Relationship

Phone: Home Work Mobile

Address: Street City State Zip

Name: Last First Relationship

Phone: Home Work Mobile

Address: Street City State Zip

Name: Last First Relationship

Phone: Home Work Mobile

Address: Street City State Zip

(Continued)

SECTION III: SPECIFIC PERSONS NOT AUTHORIZED TO PICK UP CHILD
(Please include a copy of appropriate court order or legal documentation.)

Name: Last First Relationship

Name: Last First Relationship

Name: Last First Relationship

SECTION IV: EMERGENCY CONTACT PERSONS
(Other than parents/guardians.)

Name: Last First Relationship

Phone: Home Work Cell

Address: Street City State Zip

Name: Last First Relationship

Phone: Home Work Cell

Address: Street City State Zip

SECTION IV: MEDICAL INFORMATION

Doctor's name: **Phone:**

Doctor's address: Street City State Zip

Allergies:

Chronic medical condition(s): (e.g. diabetes, heart disease, hearing aids, asthma, epilepsy, etc.)

Medication(s) student is currently taking: ○ **NONE** ○ **SEE BELOW**

Is medication needed at school? ○ **YES** ○ **NO** **Medication name:**
(If yes, complete the medication form located in the school handbook.)

Hospital preference: **City:**

Medical insurance company: **Policy #:**

Dentist's name: **Phone:**

Dentist's address: Street City State Zip

SECTION VI: MEDICAL AUTHORIZATION
I give the school permission to take my child to a hospital to receive emergency treatment. I hereby consent to any x-ray examination, medical or surgical diagnosis or treatment, and hospital care to be rendered to my child under the general or direct supervision and upon the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act. I also consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered to my child by a dentist under the provisions of the Dental Practice Act. I authorize the medical facility to release my child into the custody of a school representative should hospital care no longer be needed. I understand that this is only in an extreme emergency and when the parent or legal guardian cannot be reached. I understand that I am responsible for any expenses incurred by the medical and/or dental diagnosis or treatment. I agree to pick up my child if he/she is sick or injured. If I cannot be reached the above emergency contacts can be called to pick up my child.

Signature _____ **Date**

SECTION VII: STUDENT RECORDS UPDATE
(I understand that I must keep my child's records up to date with current information.)

Print

_____
Parent or Legal Guardian's Signature **Date**