EMERGENCY INFORMATION FORM

STUDENT NAME:_____ SEX: ____ GRADE:_____
Last, First, Middle

STUDENT NAME:_____ SEX: ____ GRADE:_____
Last, First, Middle

STUDENT NAME:_____ SEX: ____ GRADE:_____
Last, First, Middle

STUDENT NAME:_____ SEX: ____ GRADE:_____
Last, First, Middle

Mother/Guardian:_____Home:_____Cell:_____Work:_____
Last, First

ADDRESS:_____ CITY, STATE, ZIP:_____

Father/Guardian:_____Home:_____Cell:_____Work:_____
Last, First

ADDRESS:_____ CITY, STATE, ZIP:_____

Please list three additional family members or friends that can be called in case the school is unable to reach the parents in the event of your child's illness:

1)Name:_____ Relationship to Child_____ Phone Number_____

2)Name:_____ Relationship to Child_____ Phone Number_____

3)Name:_____ Relationship to Child_____ Phone Number_____

IMPORTANT MEDICAL INFORMATION: Please list any medical conditions, such as diabetes, allergic reactions to bee's, food or medications etc.:

DOCTORS NAME:

_____
NAME ADDRESS OFFICE NUMBER

I authorize school personnel and medical authorities to give medical treatment as necessary to my child.
PARENT/GUARDIAN
SIGNATURE:_____DATE:_____

IN AN EMERGENCY, THE SCHOOL OFFICE WILL CONTACT THE MOTHER / FATHER OR GUARDIAN AND TAKE THE STUDENT TO SAINT JOSEPH HOSPITAL EMERGENCY ROOM. PLEASE SIGN BELOW TO AUTHORIZE SUCH ACTION. PLEASE WRITE ANY NOTATIONS BELOW IF NECESSARY.

PARENT/GUARDIAN SIGNATURE:_____DATE:_____