Student Emergency Information 2017-2018

STUDENT First and Last Name	**Grade**	
	Teacher	
	D.O.B.	

Primary Address ______ City ______ State ______ Zip ______

Secondary Address (if applicable) ______ City ______ State ______ Zip ______

STUDENT LIVES WITH (check one):

Both Parents	Father Only	Mother Only	Guardian	Father/Stepmother	Mother/Stepfather
☐	☐	☐	☐	☐	☐

PARENT CONTACTS:

Name ______ Work Hours ______

Employer ______ Position ______

Name ______ Work Hours ______

Employer ______ Position ______

PARENT PHONE CONTACTS: List phone numbers in order of contact preference in case of emergency (check type).

		Cell	**Home**	**Work**
Phone #1 ______	Name ______			
Phone #2 ______	Name ______			
Phone #3 ______	Name ______			
Phone #4 ______	Name ______			

EMAIL CONTACT: Email addresses will be used for school and teacher correspondence. Please list all addresses you would like to receive email to. One address is required.

Email #1 ______

Email #2 ______

Email #3 ______

 Student Name: ______________________

Emergency Contacts (Required)

Who to call if Parent Contacts are not available.

Name ______________________ Relationship ______________

Phone #1 ______________ cell home work Phone #2 ______________ cell home work

Name ______________________ Relationship ______________

Phone #1 ______________ cell home work Phone #2 ______________ cell home work

OTHERS ALLOWED TO PICK UP STUDENT (Optional): Please notify the office whenever someone not on the list will be picking up your child.

		Cell	Home	Work
Name ______________	Phone ______________			
Name ______________	Phone ______________			
Name ______________	Phone ______________			

Student Health Information

Medical Conditions – check all that apply NONE

Asthma	Internal Irregularities	Deafness	Kidney
Convulsive Seizures	Surgical	Diabetes	Sight Impairment
Fractures	Arthritis	Wears Glasses	Heart

Other ______________ Describe Condition: ______________________

Allergies – check all that apply NONE

Bee Sting Allergy – Mild / Severe Other Allergy – Mild / Severe

Describe Allergy: ______________________

Physical Disability – describe if applicable NONE

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Waiver for Medical Treatment

If emergency treatment is required, and the parents or legal guardians cannot be reached immediately, your signature in the space provided below authorizes All Saints School to exercise their own judgment in calling the physician named above or, if not available, to transport the student to a hospital emergency room. Likewise, your signature below is not sufficient for the release of confidential information protected by Federal Law.

Parent/Custodian Signature ______________________ Date Signed ______________

Preferred Hospital ______________________

Preferred Physician ______________________ Physician Phone ______________