



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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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 _____



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

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 _____