



# Student Emergency Information 2018-2019

<b>STUDENT</b>

<b>Grade</b>	
<b>Teacher</b>	
<b>D.O.B.</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).

	<b>Cell   Home   Work</b>
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 \_\_\_\_\_