Student Emergency Information 2019 - 2020

STUDENT	Grade	
First and Last Name	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. <u>One address is required</u>.

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

_____

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 _____