Student Emergency Information 2015-2016

Student:	

Teacher:	Grade:
D.O.B:	Age:

Student's Primary Residence:

Address:		
City:	State:	Zip:

Home Phone:
Email:

Primary Parent(s) Contact Information:

Name:	

Address:		
City:	State:	Zip:
Home Phone:		
Cell Phone:		
Work Phone:		
Fax:		
Email:		

Place of Employment:
Position:
Work Hours:

Secondary Parent(s) Contact Information (if applicable):

Name:	

Address:		
City:	State:	Zip:
Home Phone:		
Cell Phone:		
Work Phone:		
Fax:		
Email:		

Place of Employment:
Position:
Work Hours:

Other Contacts: (Mandatory)

Persons to reach if primary and secondary parents are not available

Other Contact Information:

Name:		
Relation to child:		
Address:		
City:	State:	Zip:
Home Phone:		
Cell Phone:		
Work Phone:		
Fax:		
Email:		

Other Contact Information:

Name:		
Relation to child:		
Address:		
City:	State:	Zip:
Home Phone:		
Cell Phone:		
Work Phone:		
Fax:		
Email:		

Student Health Information:

Please check all medical conditions that apply to student:

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

Describe Condition: _____

☐ Bee Sting Allergy ☐ Mild ☐ Severe

☐ Other Allergy ☐ Mild ☐ Severe

Describe Allergy: _____

☐ Physical Disability

Describe Disability: _____

Preferred Hospital:	Preferred Physician:
Persons allowed to pick up Student:	
Name:	Phone:
Name:	Phone:
Name:	Phone:
Name:	Phone:

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: _____