

## Emergency Information

**Student Name:** \_\_\_\_\_ **Student Birthdate:** \_\_\_\_\_

Father/Guardian: \_\_\_\_\_ Mother/Guardian: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

City-State-Zip: \_\_\_\_\_ City-State-Zip: \_\_\_\_\_

Employer: \_\_\_\_\_ Employer: \_\_\_\_\_

Home Tel #: \_\_\_\_\_ Home Tel #: \_\_\_\_\_

Work Tel #: \_\_\_\_\_ Work Tel #: \_\_\_\_\_

Cell Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

Primary Email Address: \_\_\_\_\_

Student Lives With: \_\_\_\_\_

Custody Notes: \_\_\_\_\_

Religion: \_\_\_\_\_ Parish Affiliation: \_\_\_\_\_

Persons Authorized to Pick Up Child:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Persons **Not** Authorized to Pick Up Child (Court Order/Legal Documentation Required):

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Emergency Contacts Other Than Parents/Guardians:

Name & Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Name & Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

### **Medical Information**

Allergies: \_\_\_\_\_

Chronic Medical Conditions: \_\_\_\_\_

Medications: \_\_\_\_\_

Doctor's Name: \_\_\_\_\_ Doctor's Telephone #: \_\_\_\_\_

Hospital Preference (Name & City): \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_

### **Medical Authorization**

I give the school my permission to take my child to a hospital to receive emergency treatment. I hereby consent to any x-ray examination, medical or surgical diagnosis or treatment, and hospital care to be rendered to my child under the general or direct supervision and upon the advice of a physician and surgeon licensed under the provisions of the Medical Practice Act. I also hereby consent to any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered to my child by a dentist under the provisions of the Dental Practice Act. I authorize the medical facility to release my child into the custody of a school representative should hospital care no longer be needed. I understand that this is only in an extreme emergency and when the parent or legal guardian cannot be reached. I understand that I am responsible for any expenses incurred by the medical and/or dental diagnosis or treatment. I agree to pick up my child if he/she is sick or injured. If I cannot be reached, the above emergency contacts can be called to pick up my child.

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_