DIOCESE OF ALLENTOWN

Emergency Information 20__-20_

School ____

1. FAMILY INFORMATION

Student Name:____ Grade:________________

Address_____________________________________ City__________________ Zip__________________

Home Telephone #(___) ____________________ Home E-Mail____________________________________

Date of Birth____________________________ Place of Birth__________________________________

Public School District_____________________________Bus Rider_____Walker______Car Rider______

2. PARENT/GUARDIAN INFORMATION

Student lives with: ______Parents ________Mother_________Father__________Other

Father's/Guardian's Name____ Home Tel. (___)_____________

Employer______________________________________Work Tel. (___)_______________(ext.)__________

Cell Tel. # (___)__________Pager #(___)___________E-Mail __________________________________

Mother's/Guardian's Name____ Home Tel. (__)______________

Employer______________________________________Work Tel.(____)___________(ext.)___________

Cell Tel. #(____)__________Pager #(___)____________E-Mail_____________________________________

Parents/Guardians listed above have permission to pick up the child unless otherwise indicated. Notify the school principal immediately if there are any court orders restricting non-custodial parents or others from contact with the child. Provide the principal with a copy of the order.

3. CHILD CARE PROVIDER INFORMATION

Those designated below are authorized to pick up my child from school in an emergency:

Child Care Provider's Name_________________________Relationship to Child_______________________

Home Tel. # (__)____________________Work Tel. # (___)___________________.(ext.).#______________

Cell #(___)_____________________ .Pager #______ E-Mail______________________________________

4. LOCAL CONTACT INFORMATION

1. Local Contact's Name______________________________Relationship to Child____________________

Home Tel. # (__)____________________Work Tel. # (___)___________________.(ext.).#______________

Cell #(___)_____________________ .Pager #______ E-Mail______________________________________

2. Local Contact's Name______________________________Relationship to Child____________________

Home Tel. # (__)____________________Work Tel. # (___)___________________.(ext.).#______________

Cell #(___)_____________________ .Pager #______ E-Mail_____________________________________

5. MEDICAL/PHYSICAL INFORMATION

Doctor's Name____Tel. #(____)____________________

Hospital Preference____________________________Second Choice ______________________________

Insurance Company_______________________Policy No.________________Group No.________________

Dentist's Name____ Tel. # (___)______________

In a medical emergency, we hereby authorize the school to seek emergency medical assistance for our child if we cannot be reached.

Parent/Guardian Signature____________________Parent/Guardian Signature___________________Date__________

Please keep a copy of this form for your records. IMPORTANT: Please update your school immediately if any information changes.

STUDENT HEALTH INFORMATION

Student's Name____Date of Birth____________________

Grade/Teacher______/_______________________________________ Home Tel.#(___)________________

Does your child have a history of any of the following conditions? If so, please explain type of medical treatment.

YES	NO	
____	___	ADD/ADHD____
____	___	Asthma____
____	____	Diabetes____
____	____	Food or Drug Allergy____
____	____	Bee Sting Allergy____
____	____	Seizure Disorder____
____	____	Condition Limiting Physical Education_______________________________________
____	____	Migraine Headaches____
____	____	Other Chronic or Recurrent Conditions_______________________________________
____	____	Glasses/Contacts (Please Circle) (When to be worn)__________________________
____	____	Presently Taking Medications____

Names of Medication	Reasons for Taking Medication
___________________________________	___________________________________
___________________________________	___________________________________
___________________________________	___________________________________

In the event that my child should become seriously-ill or injured-while in school and require prompt emergency care, I give my permission to the attending physician for any necessary emergency medical treatment.

Parent/Guardian Signature____ Date____________________

Please Print Name of Parent Guardian Signature____

Parent/Guardian Signature____ Date____________________

Please Print Name of Parent/Guardian Signature____

Please List Siblings and Grades:

____ ____________

____ ____________

____ ____________