

Student Emergency Information

Student Name: _____ Birth Date: _____

Address: _____

Parent/Guardian Name: _____

Home Phone: _____ Cell Phone: _____

EMERGENCY CONTACT IF PARENT CAN NOT BE REACHED:

1. Name: _____ Phone: _____ Relationship: _____

2. Name: _____ Phone: _____ Relationship: _____

SPECIAL HEALTH CONDITIONS/ALLERGIES:

(Please describe condition and list any medications prescribed.)

Health Conditions:

Allergies:

Medications Prescribed:

PHYSICIAN OF CHOICE: _____ PHONE: _____

HOSPITAL OF CHOICE: _____

If you, or responsible adult, and physician of choice as stated above, can not be reached in an emergency, and if in the judgment of school/parish authorities immediate attention and/or hospital attention is indicated, do you AUTHORIZE responsible school/parish authorities to send your child (properly accompanied) to an available hospital or physician?

YES _____

NO _____

Parent/Guardian Signature: _____ Date: _____