

St. Patrick's School Emergency Information Form

2008-09

Date _____ Student's Date of Birth _____ Grade _____ Teacher _____

Student's Name _____
Last First Middle

Mailing Address** _____
Street City Zip Code

Who is the **primary person** to be contacted during school hours? _____

Phone number 1: _____ **Phone number 2:** _____

Student Living with Both Parents Father Mother Split Custody Guardian Other

If parents have split custody please explain who has custody and when (attach verification):

Father's Name _____
Last First Home ()

Address _____
Street City Zip Work ()
Cell ()

E-Mail Address _____

Employer _____
Name Job Title

Address _____
Address

Mother's Name _____
Last First Home ()

Address _____
Street City Zip Work ()
Cell ()

E-Mail Address _____

Employer _____
Name Job Title

Address _____
Address

List two people who will assume temporary care of your child if you cannot be reached at home, work or by cell.

1. _____
Name Relationship

Phones: Home Business Cell/Pager

2. _____
Name Relationship

Phones: Home Business Cell/Pager

**** This is the address that will be used if it is necessary for the school to mail you any information.**

EXPLAIN ANY MEDICAL PROBLEMS THE SCHOOL SHOULD BE AWARE OF

Allergies: _____

Procedures to follow in case of this medical problem _____

Physician's Name _____

Address _____ Phone _____

Insurance Medical Coverage _____

ID# _____ Hospital Preference _____

Dentist's Name _____

Address: _____ Phone: _____

Dental Coverage: _____

ID# _____

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

In the event of serious emergency, and none of the above named persons can be contacted, I authorize school officials to call my family doctor or, if the situation demands to transfer my child to nearest hospital for the necessary emergency care. I consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care, which is deemed advisable by, and is rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the Medical staff of a certified hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital. I **hereby agree to bear all costs incurred as a result of the foregoing:**

State: Yes _____ No _____

For the school year 2008-2009

Signature of Parent/Guardian

Date