

EMERGENCY INFORMATION

FAMILY LAST NAME _____

ADDRESS _____
Street City Zip

HOME TELEPHONE _____ Mother **Cellular** _____ **Pager** _____

Father **Cellular** _____ **Pager** _____

First Child _____ GRADE _____
First Middle Last

Second Child _____ GRADE _____
First Middle Last

Third Child _____ GRADE _____
First Middle Last

PARENT INFORMATION (It is essential that you update the following information as soon as it changes since this information is used in the event of an **Emergency**.)

Father/Guardian

Mother/Guardian

Name _____

Employer Name: _____

Working Hours: _____

Telephone: _____

Email Address: _____

(it is very important that you include your email in order for you to access MystudentsProgress.com)

Do you wish to be called at work? ___ Yes ___ No ___ Yes ___ No

Name and Address of Two Local Persons Who Will Care for Your Child in an Emergency (Please inform these individuals of your intentions in the event they need to be contacted.)

Name _____ Relationship _____

Address _____ Phone _____

Name _____ Relationship _____

Address _____ Phone _____

(OVER)

AUTHORIZATION FOR TREATMENT OF MINOR

In the event of serious emergency, and none of those listed on this form can be contacted, I authorize school officials to call my family doctor or, if the situation demands, to transfer my child to the 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 physical or at the hospital.

I understand that the school does not assume responsibility for payment of a physician. If our family physician cannot be reached, the school may choose a physician. _____ **YES** _____ **NO**

For the school year 2011 - 2012

Signature of Parent/Guardian

Date

Name of Family Physician _____ Phone _____

Preferred Hospital _____

Medical Information:

Medical Insurance Provider _____ Medical Record Number _____

Child Name

Any Known Allergies

Christ is among us!