STUDENT EMERGENCY INFORMATION
SCHOOL YEAR 2015-2016

Applications must be filled out completely to complete the registration process.
An Emergency Information form must be filled out for EACH child. Please PRINT clearly.

STUDENT INFORMATION GRADE: _____ TEACHER: _____

LAST NAME: _____ FIRST: _____ DOB: _____

PHYSICAL ADDRESS: _____ CITY: _____ ZIP: _____

MAILING ADDRESS: _____ CITY: _____ ZIP: _____

GENDER: _____ HOME PHONE: _____ SSN: _____

INSURANCE COMPANY NAME: _____ POLICY NO.: _____

PARENTAL/GUARDIAN INFORMATION

MOTHER'S NAME: _____ WORK#: _____ CELL: _____

FATHER'S NAME: _____ WORK#: _____ CELL: _____

EMERGENCY CONTACTS

IN CASE OF EMERGENCY IN WHICH THE PARENTS CANNOT BE REACHED, PLEASE CALL: (MUST BE A U.S. NUMBER)

LAST: _____ FIRST: _____ RELATION: _____ PHONE#: _____
LAST: _____ FIRST: _____ RELATION: _____ PHONE#: _____

THE FOLLOWING PEOPLE MAY PICK UP MY CHILD FROM THIS SCHOOL:

LAST: _____ FIRST: _____ RELATION: _____ PHONE#: _____
LAST: _____ FIRST: _____ RELATION: _____ PHONE#: _____
LAST: _____ FIRST: _____ RELATION: _____ PHONE#: _____
LAST: _____ FIRST: _____ RELATION: _____ PHONE#: _____
LAST: _____ FIRST: _____ RELATION: _____ PHONE#: _____

HEALTH INFORMATION

1. List health conditions such as heart disease, diabetes, epilepsy, asthma, eye/ear problems, blood pressure abnormalities, severe food/drug allergies, etc. **A note from your child's physician is required for heart condition, diabetes, epilepsy/seizures, or asthma with use of inhaler.** (Please write "none" where applicable)

_____
_____

2. Is there any need for medication or inhalers at school? If so, list medication to be taken or kept at school?

_____
_____

3. Are there any special concerns or limitations regarding athletic participation for your child?

_____
_____

CONSENT TO TREAT

I, the undersigned, do hereby authorize the officials of Our Lady of Sorrows School to contact directly the person named on this form, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency for the health of said child.

In the event physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold Our Lady of Sorrows School financially responsible for the emergency care and/or transportation for said child.

_____
PLEASE PRINT PARENT NAME

_____ _____
PARENT SIGNATURE DATE

PHYSICIAN: _____ PHYSICIAN PHONE#: _____

IN CASE OF AN EMERGENCY REQUIRING PROFESSIONAL CARE, I/WE AUTHORIZE THE SCHOOL OFFICIALS TO HAVE MY/OUR CHILD TREATED BY EMS STAFF AND/OR TRANSPORTED TO _____ HOSPITAL.