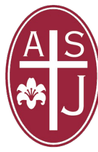

Academy of St. Joseph

EMERGENCY CONTACT INFORMATION FORM

This form must be completed every year.

Child's Name: Birth Date: Grade:

Address: Telephone:

Parent/Guardian [1] – please specify relationship | Parent/Guardian [2] – please specify relationship

Full Name

Home Address

Home Phone

Business Address/Phone

Cell Phone

E-mail Address

If parents are divorced or separated, whom should we contact first: Parent 1( ) Parent 2( ) Both ( )

Daytime Caretaker (if other than parent) / Person authorized to regularly pickup your child at the end of the school day.

Name:

Address:

Telephone:

Weekday Schedule:

Please list below three people we may contact in case of any emergency if none of the above are available. Please remember that one contact person should be **someone who lives in the neighborhood or is readily available.**

Name: Telephone: Relationship:

Name: Telephone: Relationship:

Name: Telephone: Relationship:

Consent for emergency medical treatment

In the event that the child's parents are not available, I authorize the Academy of St. Joseph administration and delegated staff to obtain emergency medical treatment for my child. I expect family and/or contact individuals to be notified as soon as possible regarding emergency interventions. I permit the administration and staff to care for my child if he/she becomes ill during the school year. I permit the school office staff to contact my child's health care providers for medical instructions, health form updates and to report a medical/injury occurrence.

Signature of Parent/Guardian **Relationship** **Date**

Doctor's Name: Office Telephone:

Dentist's Name: Office Telephone:

Insurance Company:

Policy and/or Group Number:

Name of Insured:

Allergies: Current Medications: