EMERGENCY INFORMATION CARD

SCHOOL: **PARISH/OUT OF PARISH:**

NAME OF CHILD		DATE OF BIRTH	SEX ◯ MALE ◯ FEMALE
HOME ADDRESS		ZIP CODE	HOME PHONE
MOTHER OR GUARDIAN'S NAME	BUSINESS PHONE	FATHER OR GUARDIAN'S NAME	BUSINESS PHONE
BUSINESS ADDRESS		BUSINESS ADDRESS	

IN EMERGENCY (AND PARENT CANNOT BE REACHED) NOTIFY:

NAME	HOME PHONE	RELATIONSHIP TO CHILD
HOME ADDRESS	BUSINESS ADDRESS AND PHONE	
NAME	HOME PHONE	RELATIONSHIP TO CHILD
HOME ADDRESS	BUSINESS ADDRESS AND PHONE	

☐ I authorize transportation for my child in case of an emergency.

☐ I authorize the staff of _____ to procure surgical, medical, hospital or dental care for my child in the event of injury or illness if I cannot be contacted to make arrangements for such treatment. It is understood by me that the expense of this service will be accepted by me.

☐ I do not authorize the staff of _____ to oversee any medical treatment in my absence.

☐ I authorize _____ to assume responsibility for my child(ren) in the event of a school disaster when I cannot be there.
Relative / Friend / Neighbor

INSURANCE CARRIER _____ NUMBER _____ SOCIAL SECURITY # _____

_____

WITNESS DATE SIGNATURE OF PARENT/GUARDIAN

IF MEDICAL CARE IS NECESSARY CALL:

NAME OF DOCTOR	ADDRESS	PHONE
NAME OF DENTIST	ADDRESS	PHONE

Please check any of the spaces below which describe a health problem your child has which might require attention at school. If your child has no such health problems, check "None of the above."

- ☐ Blood disease (sickle cell anemia, aplastic anemia, malaria, hemophilia, etc.)
- ☐ Heart problem requiring limitations
- ☐ Diabetes
- ☐ Food allergy requiring immediate attention
- ☐ Digestive disorder (ulcers, colitis)
- ☐ Hearing impairment requiring preferential seating; hearing loss
- ☐ Insect sting allergy -- severe -- requiring immediate attention
- ☐ Malignancy (leukemia, sarcoma, Hodgkin's dise ase, etc.)
- ☐ Neurological problem (cerebral palsy, hydrocephalus, etc.)
- ☐ Orthopedic problem requiring limitations ("brittle bone disease," rheumatoid arthritis)
- ☐ Respiratory problem -- severe -- requiring limitations (asthma, cystic fibrosis, etc.)
- ☐ Seizure disorder (epilepsy, etc.)
- ☐ Urinary tract disorder (nephritis, absence of kidney or bladder, etc.)
- ☐ Vision impairment requiring preferential seating, or complete vision loss
- ☐ None of the above

Information/Instructions:

Special Dietary Instructions:

Immunization/ Booster Dates: _____

Date of last visit to the doctor: _____

Authorized person(s) to pickup child: _____ _____