EMERGENCY SHEET

Student's last name _____ First name_____ Middle Initial _____
DOB_____

(other children at St. Anthony's) _____ DOB_____

(First and middle initial)

_____ DOB_____

_____ DOB_____

_____ DOB_____

Address _____

Home Phone Number _____

Parents or Guardians

Mother's Name _____ Father's Name _____

address _____ address _____

Home phone _____ Home phone _____

Cell phone _____ Cell phone _____

Email address _____

Mother's place of employment _____ phone _____

Father's place of employment _____ phone _____

In an emergency if the school is unable to contact a parent, call:

Name _____ Phone _____

Name _____ Phone _____

If the school is unable to reach me or the persons I have designated, I hereby authorize the school to call the physician indicated below and to follow his/her instructions.

Signature of parent/guardian _____

Physician's name _____

Office address of physician _____

Phone # of physician _____

If your child is in daycare, please fill out below. This is a state requirement.

Mother Employment Address: _____

Father Employment Address: _____

MEDICAL MATTERS

I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child. (Of the following statements pertaining to medical matters, sign only those that are applicable.)

Child's name _____

Parent's name _____

Phone number: work _____ home _____

Cell phone _____

Emergency Medical Treatment In the event of an emergency, I hereby give permission to transport my child to the hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the numbers above, contact:

Name _____

Relationship _____

Phone number: work _____ home _____

Cell phone _____

Family doctor _____ Phone number _____

Family Health Plan Carrier _____ Policy # _____

Signature _____ Date _____

Other Medical Treatment In the event it comes to the attention of the teachers or chaperones associated with the activity that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever, diarrhea, I want to be called.

Signature _____ Date _____

Medications My child is taking medication at present. My child will bring all medications necessary, and such medications will be well labeled and in the original container with names of medications. Concise directions for seeing that the child takes such medications including dosage and frequency of dosage are as follows:

_____

_____

Signature _____ Date _____

(please turn paper over)

No medication of any type, whether prescription or non-prescription, may be administered to my child unless the situation is life threatening and emergency treatment is required.
Signature _____ Date _____

I hereby grant permission for non-prescription medications (such as non-aspirin products, i.e. acetaminophen or ibuprofen, throat lozenges) to be given to my child, if deemed appropriate.
Signature _____ Date _____

Specific medical information

The school will take reasonable care to see that the following information will be held in confidence:

Allergic reactions (medications, food, plants, insects, etc.) _____
_____
_____
_____
_____
You should be aware of these special medical conditions of my child _____
_____
_____
_____

I, _____have determined

that Mrs. Campazano/Mrs. Hefti/Mrs. Lopez/Mrs. Sokol is/are competent to give or apply medication to my child(ren).

Signature_____ Date_____