

Form #5

Last Name Of Student(s) _____

Student Names:

- 1. _____ 2. _____ 3. _____
- 4. _____ 5. _____ 6. _____

Primary Address: _____

School District: _____

Primary Phone Number: () _____

Primary Email Address: _____

Adults living at this address (first & last names) _____

Secondary Address _____

Secondary Phone () _____

Secondary Email Address: _____

Adult living at this address (first & last names) _____

Father/Guardian Name (First & Last) _____

Cell Phone () _____ Work Phone () _____

Business Name: _____ Occupation: _____

Work Days/Hours: _____

Mother/Guardian Name (First & Last) _____

Cell Phone () _____ Work Phone () _____

Business Name: _____ Occupation: _____

Work Days/Hours: _____

If I cannot be reached if my child needs to be picked up, he/she may be taken to the home of:

Name: _____ Phone () _____
Relationship _____

Name: _____ Phone () _____
Relationship _____

Student's Doctor _____ Phone () _____

Student's Dentist _____ Phone () _____

Please describe how your children will be arriving/departing from school:

Arrival: _____

Departure: _____

Continue on Reverse Side

Form #5

ST. DOMINIC SCHOOL EMERGENCY FORM (PAGE 2)

The following information issued to the school for the purpose of updating records of health issues that may affect children during the school day. It is important that the school be aware of health issues in order to attempt to provide the safest environment possible for each child.

REMINDER: ANY medication taken at school must be kept in the school office along with parental/guardian medication consent form completed and on file.

Child's Name: _____

Allergies: _____

Medications: _____

Asthma: Y N

Diabetes: Y N

Glasses Required? Y N

Hearing Equipment Required? Y N

Other Concerns: _____

Child's Name: _____

Allergies: _____

Medications: _____

Asthma: Y N

Diabetes: Y N

Glasses Required? Y N

Hearing Equipment Required? Y N

Other Concerns: _____

Child's Name: _____

Allergies: _____

Medications: _____

Asthma: Y N

Diabetes: Y N

Glasses Required? Y N

Hearing Equipment Required? Y N

Other Concerns: _____

Child's Name: _____

Allergies: _____

Medications: _____

Asthma: Y N

Diabetes: Y N

Glasses Required? Y N

Hearing Equipment Required? Y N

Other Concerns: _____

Child's Name: _____

Allergies: _____

Medications: _____

Asthma: Y N

Diabetes: Y N

Glasses Required? Y N

Hearing Equipment Required? Y N

Other Concerns: _____

Child's Name: _____

Allergies: _____

Medications: _____

Asthma: Y N

Diabetes: Y N

Glasses Required? Y N

Hearing Equipment Required? Y N

Other Concerns: _____

If additional space is needed to list students and/or health concerns, please add a separate sheet.

I hereby authorize the school principal, nurse or school staff member to call the doctors' names above if an emergency exists and I cannot be reached. In the event of an emergency and neither parent can be reached, I give the principal/school permission to call an ambulance or transport my child to the dentist/doctor/hospital.

Yes _____ No _____

Insurance Carrier Name _____ Policy# _____

Hospital Preference _____

If at any time this information changes, please notify the office.

Parent/Guardian Signature: _____ Date: _____