DIOCESE OF ALLENTOWN
Emergency Information 20___ - 20___
Immaculate Conception School

1. FAMILY INFORMATION

Student Name_____ ☐ Grade_____

Address_____ City _____ State ____ Zip _____

Home Telephone # (____)_____ Home E-Mail Address _____

Date of Birth_____ Place of Birth _____

Public School District_____ ☐ Bus Rider ☐ Walker ☐ Carline ☐ Aftercare

Religious affiliation ☐ Catholic ☐ Non-Catholic If Catholic, Parish where Child is registered _____

2. PARENT/GUARDIAN INFORMATION

Student lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other _____

Father's/Guardian's Name_____ Home Tel.# (_____)_____

Employer_____ Work Tel.# (_____) _____(ext.) _____

Cell Tel. # (_____)_____ Pager #_____ E-Mail _____

Mother's/Guardian's Name_____ Home Tel.# (_____) _____

Employer_____ Work Tel.# (_____) _____(ext.) _____

Cell Tel. # (_____)_____ Pager #_____ E-Mail _____

Parents/Guardians listed above have permission to pick up the child unless otherwise indicated. Notify the school principal immediately if there are any court orders restricting non-custodial parents or others from contact with the child. Provide the principal with a copy of the order.

3. CHILD CARE PROVIDER INFORMATION

Those designated below are authorized to pick up my child from school in an emergency:

Child Care Provider's Name_____ Relationship to Child _____

Home Tel. # (_____) _____ Work Tel. # (_____) _____ (ext.) _____

Cell Tel. # (_____)_____ Pager #_____ E-Mail _____

4. LOCAL CONTACT INFORMATION

1. Local Contact's Name_____ Relationship to Child _____

Home Tel. # (_____) _____ Work Tel. # (_____) _____ (ext.) _____

Cell Tel. # (_____)_____ Pager #_____ E-Mail _____

2. Local Contact's Name_____ Relationship to Child_____

Home Tel. # (_____) _____ Work Tel. # (_____) _____ (ext.) _____

Cell Tel. # (_____)_____ Pager #_____ E-Mail _____

5. MEDICAL/PHYSICAL INFORMATION

Doctor's Name_____ Tel. # (_____)_____

Hospital Preference_____ Second Choice _____

Insurance Company_____ Policy No. _____ Group No. _____

Dentist's Name_____ Tel. # (_____) _____

In a medical emergency, we hereby authorize the school to seek emergency medical assistance for our child if we cannot be reached.

_____ _____ _____

Parent/Guardian Signature Parent/Guardian Signature Date **COMPLETE OTHER SIDE**

STUDENT HEALTH INFORMATION

Student's Name_____ Date of Birth_ _____

Grade/Teacher_____/_____ Home Tel.#(____) _____

Does your child have a history of any of the following conditions? If so, please explain type of medical treatment.

YES	NO	
_____	_____	ADD/ADHD
_____	_____	Asthma_____
_____	_____	Diabetes_____
_____	_____	Food or Drug Allergy_____
_____	_____	Bee Sting Allergy_____
_____	_____	Seizure Disorder_____
_____	_____	Condition Limiting Physical Education_____
_____	_____	Migraine Headaches_____
_____	_____	Other Chronic or Recurrent Conditions_____
_____	_____	Glasses/Contacts (Please Circle) (When to be Worn)_____
_____	_____	Presently Taking Medications

Names of Medication	Reasons for Taking Medication
_____	_____
_____	_____
_____	_____

In the event that my child should become seriously ill or injured while in school and require prompt emergency care, I give my permission to the attending physician for any necessary emergency medical treatment.

_____ _____ _____ _____

Parent/Guardian Signature Date Parent/Guardian Signature Date

_____ _____

Print Parent/Guardian name Print Parent/Guardian name

Please List Siblings and Grades enrolled:

Sibling name	Grade

Sibling name	Grade

Please keep a copy of this form for your records.

IMPORTANT: if any of this information changes, Please inform your school immediately.