HOLY INFANCY SCHOOL
My School, My Family • Mi Escuela, Mi Familia

DIOCESE OF ALLENTOWN
Emergency Information 2020-2021

1. **FAMILY INFORMATION**

Student Name:_____ Grade:_____

Address:_____City:_____ State:_____ Zip Code:_____

Home Tel: (_____)_____ Home E-mail Address:_____

Student Date of Birth:_____ Birthplace:_____

Public School District:_____ Bus Rider _____ Walker_____ Car Rider_____

2. **PARENT/GUARDIAN INFORMATION**

Student lives with: Parents_____ Mother_____ Father_____ Other_____

Father's/Guardian's Name:_____ Home Tel. _____ Cell # _____

Employer:_____ Work Tel. #_____ (extension)_____

E-mail:_____ Pager #_____

Mother's/Guardian's Name:_____Home Tel._____Cell #_____

Employer:_____Work Tel. #_____(extension)_____

E-mail:_____Pager #_____

Parents/Guardians listed above have permission to pick up the child unless otherwise indicated. Notify the school 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 court 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. #:_____ Cell #:_____Pager:_____E-mail:_____

4. **LOCAL CONTACT INFORMATION**

a. Local Contact's Name:_____ Relationship to Child:_____
Home Tel. #_____Cell Tel. #_____ Work Tel. #_____E-mail:_____

b. Local Contact's Name:_____ Relationship to Child:_____
Home Tel. #_____Cell Tel. #_____ Work Tel. #_____E-mail:_____

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

_____ _____ _____

Parent/Guardian Signature Parent/Guardian Signature Date

Please keep a copy of this form for your records. IMPORTANT: Please update your school immediately if any information changes.

STUDENT HEALTH INFORMATION

5. MEDICAL/PHYSICAL INFORMATION

Doctor's Name:_____ Tel. #_____

Hospital Preference:_____ Hospital second choice:_____

Dentist's Name:_____Tel. #_____

Insurance Company:_____Policy #_____ Group #_____

Student's Name:_____ Date of Birth:_____

Grade:_____ Teacher:_____

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 Alergy_____	
___	___	Seizure Disorder_____	
___	___	Condition limiting Physical Education_____	
___	___	Migraine Headaches (need doctor's note)_____	
___	___	Other chronic or recurrent conditions_____	
___	___	Glasses/contacts (please circle one & indicate when to be worn)_____	
___	___	Presently taking medications:	Names of medication / Reason for taking
			_____ _____
			_____ _____
			_____ _____

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

_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Signature	Date
_____	_____	_____
Please print name of Parent/Guardian	Please print name of Parent/Guardian	Date

Please list siblings and grades: _____ Grade_____

_____ Grade_____

_____ Grade_____

_____ Grade_____