

EMERGENCY CARD / RELEASE AND CONSENT
St. Catherine School, 2011-2012

Name of Student (Last, First, Middle) DOB _____ Grade _____

Student Address:

Street City _____ State _____ Zip _____

Home Phone # Siblings at the School: _____
(Name/Grade) _____

Student lives with (check all that apply):

____ Mother
____ Father
____ Guardian(s) (specify): _____

Father's Information:

Name (Last, First, Middle) Email Address _____

Work address: Street City _____ State _____ Zip _____

Home address: Street City _____ State _____ Zip _____
(if different from child) Work Phone: _____ Cell Phone: _____

Mother's Information:

Name (Last, First, Middle) Email Address _____

Work address: Street City _____ State _____ Zip _____

Home address: Street City _____ State _____ Zip _____
(if different from child) Work Phone: _____ Cell Phone: _____

Release and Permission to Seek Medical Treatment

In case of an accident or an emergency, I authorize a staff member of St. Catherine School to seek emergency medical treatment for my child. St Catherine School may contact the physician(s) named on the back of this card or go to the nearest emergency hospital for such emergency treatment and measures as are deemed necessary for the safety and protection of the child, at my expense.

During the school day or in case of an emergency, my child may be released to any of the individuals listed as emergency contacts on this card.

Signature _____ Date _____
(Parent or guardian)

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Emergency Contacts:

	Name and Address	Telephone Number(s)
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____
6.	_____	_____

(Attach an additional page if more space needed for emergency contacts)

Student Medical Information:

Primary Physician:

Name	Address	Phone
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Emergency Physician:

Name	Address	Phone
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Medical Conditions (e.g., diabetes, heart condition, epilepsy, etc):

Disabilities: _____

Allergies (Hay Fever, specific type of food allergies, etc.): _____

Medications: _____

Allergies to Medications: _____

Medicines to be Self-administered by the Child: _____

Dosage: _____ Frequency: _____

Medicines to be Administered by the School (IF parents/guardians and school both agree that the school shall do so): _____

Dosage: _____ Frequency: _____

DATE: _____

SIGNED: _____

PRINT NAME: _____

RELATIONSHIP TO CHILD: _____