St. Angela School
TODAY'S LEARNERS. TOMORROW'S LEADERS.

EMERGENCY INFORMATION: SCHOOL YEAR _____

STUDENT NAME	DATE OF BIRTH	GRADE	ALLERGIES / SIGNIFICANT MEDICAL HISTORY (USE REVERSE IF NECESSARY)

Parent / Guardian name _____ Day phone _____

Parent / Guardian name _____ Day phone _____

Doctor's name: _____

Doctor's phone: _____

Medical Insurance Provider: _____

Policy/Insurance #_____

Emergency contacts in care parents/legal guardians cannot be reached *(please supply three):*

1. Name: _____Relationship to child: _____

Phone #1: _____Phone #2: _____

2. Name: _____Relationship to child: _____

Phone #1: _____Phone #2: _____

3. Name: _____ Relationship to child: _____

Phone #1: _____Phone #2: _____

Medical Authorization: ***Please read and sign***

In the event that the undersigned, or my/our authorized doctor cannot be reached and in the judgment of the school principal and/or his/her authorized staff member, there is a necessity for immediate examination and/or treatment of my/our child, I/we hereby request and authorize any of the aforesaid personnel to obtain for my/our child such medical services that are deemed necessary. I/We agree to assume the financial responsibility for any diagnosis/treatment and/or medication deemed necessary.

_____

(Print Parent/Legal Guardian Name) (Signature) Date

_____

(Print Parent/Legal Guardian Name) (Signature) Date

THIS FORM WILL ACCOMPANY STUDENTS ON FIELD TRIPS. IT IS THE RESPONSIBILITY OF THE PARENTS TO UPDATE EMERGENCY INFORMATION AS NECESSARY.