Emergency Care Form

Please fill out one form per child

Note: This form will be used by SJS and the Kids Club program, please initial if your child will also attend the Kids Club_____

Student's Information			
Last name:		*Date of birth:*	
First name:		*Address:*	
Middle name:		*City/state/zip:*	
Names of siblings:		*Home phone:*	
		Cell phone:	
Where parents can be reached if not at home:			
Father		*Mother*	
Name:		*Name:*	
Employer:		*Employer:*	
Cell phone:		*Cell phone:*	
Business phone:		*Business phone:*	
Separated or divorced parents please provide additional information:			
Name:		*Relationship:*	
Employer:		*Address:*	
Cell phone:		*City/state/zip:*	
Business phone:		*(Please submit a copy of your parenting plan to be kept in a confidential office file)*	
Home phone:			
Who is authorized to assume temporary care of your child if you cannot be reached?			
Name:		*Relationship:*	
Cell phone:		*Address:*	
Business phone:		*City/state/zip:*	
Home phone:			
Name:		*Relationship:*	
Cell phone:		*Address:*	
Business phone:		*City/state/zip:*	
Home phone:			
Name:		*Relationship:*	
Cell phone:		*Address:*	
Business phone:		*City/state/zip:*	
Home phone:			
Please give the name of anyone to whom your child may NOT be released:			
Name:		*Relationship:*	
Name:		*Relationship:*	
Name:		*Relationship:*	

In case of accident or serious illness:			
In case of an accident or serious Illness, I hereby authorize Saint Joseph School to call 911 and make whatever arrangements deemed necessary for the well-being of my child. Saint Joseph School will attempt to contact the parent or legal guardian and if necessary will call the physician listed below.			
Physician's name:		*Indicate the hospital you prefer your child be transported to in case of an emergency:*	
Phone:			
Address:		*Hospital preference:*	
City/state/zip:			

Medical Information

Does your child have allergies?	☐ Yes ☐ No
If "yes," what is the allergen?	
What is the reaction?	
If he/she has an anaphylactic reaction will your child have an Epipen/and or an allergy action plan at school?	☐ Yes ☐ No
Is your child under the care of a physician currently?	☐ Yes ☐ No
If yes, please describe:	
Will an action plan be provided? (asthma, seizures, etc.)	☐ Yes ☐ No
Past hospitalizations:	
Does your child take any prescription or over-the-counter medication?	☐ Yes ☐ No
If yes, please describe:	
Does your child have any dietary restrictions?	☐ Yes ☐ No
If yes, please describe (lactose intolerant, celiac, etc):	
Is your child required to wear glasses or contacts?	☐ Yes, nearsighted ☐ Yes, farsighted ☐ No
Please describe any other visual problems:	
Does your child currently have hearing related need?	☐ Yes ☐ No
If yes, please describe:	
Does your child have tubes in his/her ears?	☐ Yes ☐ No
Please indicate any other issues that you feel it would be beneficial to share:	

Parent signature		**Date:**	