

School of Religion Parents: Please fill out the following form and return with registration.

SACRED HEART SCHOOL of RELIGION 2008-09 EMERGENCY INFORMATION FORM

Family Last Name _____

Home Phone: _____

Address: _____ City/Zip: _____

E-Mail Address _____

Student's Name: _____ Grade _____ DOB _____ SS# _____

Student's Name: _____ Grade _____ DOB _____ SS# _____

Student's Name: _____ Grade _____ DOB _____ SS# _____

Student's Name: _____ Grade _____ DOB _____ SS# _____

Student's Name: _____ Grade _____ DOB _____ SS# _____

Mother's Last Name: _____ **Mother's First Name:** _____

Business Name: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Father's Last Name: _____ **Father's First Name:** _____

Business Name: _____ Work phone: _____

Cell Phone: _____ Email: _____

PERSONS AUTHORIZED TO PICK UP YOUR CHILD FROM SOR IN THE EVENT OF AN EMERGENCY AND YOU
CANNOT BE LOCATED:

Relationship	Name	Address	Phone

Please Circle

Are you registered members of Sacred Heart Parish? YES NO

(Please continue to fill out form on back)

Please list student and explain any current medications, health conditions, and/or disabilities (i.e. diabetes, epilepsy, severe allergies, vision and/or hearing impaired, learning disability, etc.)

Student Name: _____ **Grade** _____ **Condition:** _____

Allergies (please include food allergies): _____

Past medical history that may be important: _____

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Allergies (please include food allergies): _____

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Student Name: _____ **Grade** _____ **Condition:** _____

Allergies (please include food allergies): _____

Past medical history that may be important: _____

HEALTH INSURANCE

(This information helps to speed up the process with hospital admittance in case of an emergency)

Health Insurance Policy Name and ID: _____

Health Insurance Group Number: _____

Health Insurance Telephone # _____

IN AN EXTREME EMERGENCY:

If your child should become seriously ill or injured at school and you and the physician cannot be reached within a reasonable length of time, may we have permission to take appropriate action to see that your child gets emergency hospital care? _____

Hospital preference: _____

Physician Name: _____ **Phone** _____

Dentist Name: _____ **Phone** _____

I hereby authorize the Sacred Heart School of Religion representative to give consent for any emergency medical care for my child while in the custody of Sacred Heart Catholic Church in the event I cannot be reached.

Parent's Signature _____ **Date** _____