ST. FRANCIS OF ASSISI CATHOLIC CHURCH
PARISH SCHOOL OF RELIGION
EMERGENCY INFORMATION
2017-18

EMERGENCY CONTACT:
FAMILY NAME___________________________________email address_______________________

Address____
street city state zip
Home Phone____________________ Child:___________________________ Grade______
Cell Phone/Pager(mom)___________ Child:___________________________ Grade______
Cell Phone/Pager (dad) ___________ Child:___________________________ Grade______
Child:___________________________ Grade______
****
FATHER ____
last first

MOTHER____
last first

In the event of an emergency, a parent will be contacted. Preference on parent who will be contacted:
1.______mom 2.______dad

In the event of an emergency, and a parent cannot be reached, I authorize and give permission for the following people to be contacted and pick-up my child(ren).

Name____
Phone Relationship
Name____
Phone Relationship

911
In case of a serious accident or serious illness, I request the PSR coordinator to contact me. If unable to reach me or the people designated above, I hereby authorize the PSR Coordinator/teacher to call the physician listed and to follow his/her instructions. If unable to contact the physician, I authorize the PSR coordinator or teacher to make whatever arrangements are deemed necessary.

In case of a critical emergency, I give consent for my child to be treated by emergency personnel and transported to the hospital listed above.
I will accept full financial responsibility for charges connected with emergency care and transportation and charges connected with care at a hospital.

Physician: _______________________Phone:_____________

Hospital Preference:__________________________________

____
Signature of parent or guardian date

HEALTH INFORMATION:

Please list any information that would be necessary for us to know about your child that affects their ability to learn or participate in a classroom setting. Example: ADD, ADHD, IEP, 504, etc.

Child's name:

____

____

Child's name:

____

____

Please list any medical information that would be necessary for us to know about your child.

Child's name:
______Allergies______Asthma______Diabetes______Seizures______ Heart
Medication____

Child's name:
______Allergies______Asthma______Diabetes______Seizures______Heart
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This information is confidential and will be kept in a separate binder in the PSR office.