DIOCESE OF ALLENTOWN
Emergency Information 2024-2025
St. Ann School - Emmaus

1. FAMILY INFORMATION

Student Name: _____ Grade: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Telephone # (____) _____ Home Email Address: _____

Date of Birth: _____ Place of Birth: _____

Public School District: _____ Bus Rider ☐ Walker ☐ Car Rider ☐

2. PARENT/GUARDIAN INFORMATION

Student lives with: ☐ Parents ☐ Mother ☐ Father ☐Other: _____

Father/Guardian's Name: _____ Home Phone #: _____

Employer: _____ Work #: (_____) _____ (ext.) _____

Cell #: (_____) _____ Pager #: _____ Email: _____

Mother/Guardian's Name: _____ Home Phone #: _____

Employer: _____ Work #: (_____) _____ (ext.)_____

Cell #: (_____) _____ Pager #: _____ Email: _____

Parents/Guardians listed above have permission to pick up the child unless otherwise indicated. Notify the school principal immediately if there are any court orders restricting non-custodial parents or others from contact with the child. Provide the principal with a copy of the order.

3. CHILD CARE PROVIDER INFORMATION

Those designated below are authorized to pick up my child from school in an emergency.

Child Care Provider's Name: _____ Relationship to Child: _____

Home Phone #: (_____) _____Work Phone #: (_____) _____ (ext.)_____

Cell Phone#: (_____) _____ Pager #: _____ Email: _____

4. LOCAL CONTACT INFORMATION

1. Local Contact's Name: _____ Relationship to Child: _____

Home Phone #: (_____) _____Work Phone #: (_____) _____ (ext.) _____

Cell Phone#: (_____) _____ Pager #: _____ Email: _____

2. Local Contact's Name: _____Relationship to Child: _____

Home Phone #: (_____) _____Work Phone #: (_____) _____ (ext.) _____

Cell Phone#: (_____) _____ Pager #: _____ Email: _____

5. MEDICAL/PHYSICAL INFORMATION

Doctor's Name: _____ Phone #: _____

Hospital Preference: _____ Second Choice: _____

Insurance Company: _____ Policy No. _____ Group No. _____

Dentist's Name: _____ Phone#: _____

In a medical emergency, we hereby authorize the school to seek emergency medical assistance for our child if we cannot be reached.

_____ _____ _____

Parent/Guardian Signature **Parent/Guardian Signature** **Date**

Please keep a copy of this form for your records. IMPORTANT: Please update your school immediately if any information changes.

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STUDENT HEALTH INFORMATION

Student's Name_____ Date of Birth_____

Grade/Teacher_____/_____ Home Tel.#(___)_____

Does your child have a history of any of the following conditions? If so, please explain type of medical treatment.

YES	NO	
_____	_____	ADD/ADHD_____
_____	_____	Asthma_____
_____	_____	Diabetes_____
_____	_____	Food or Drug Allergy_____
_____	_____	Bee Sting Allergy_____
_____	_____	Seizure Disorder_____
_____	_____	Condition Limiting Physical Education_____
_____	_____	Migraine Headaches_____
_____	_____	Other Chronic or Recurrent Conditions_____
_____	_____	Glasses/Contacts (Please Circle) (When to be Worn)_____
_____	_____	Presently Taking Medications

Names of Medication	Reasons for Taking Medication
_____	_____
_____	_____
_____	_____

In the event that my child should become seriously ill or injured while in school and require prompt emergency care, I give my permission to the attending physician for any necessary emergency medical treatment.

_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Signature	Date
_____	_____	_____
Please Print Name of Parent/Guardian Signature	Please Print Name of Parent/Guardian Signature	Date

Please List Siblings and Grades:

_____ _____

_____ _____

_____ _____