

CATHOLIC SCHOOL SYSTEM**ARCHDIOCESE OF ATLANTA
STUDENT EMERGENCY CARE FORM**

Student's Last Name _____ First _____ MI _____ Date of Birth _____ Age _____ Sex _____ Grade _____
Father's Name _____ Mother's Name _____

Address _____ City _____ Zip _____ Address _____ City _____ Zip _____
Phone: Hm _____ Bus _____ Cell _____ Phone: Hm _____ Bus _____ Cell _____
Name of Business _____ Name of Business _____

Person(s) To Call In Emergency When Parents Cannot Be Reached / and who may pick up the child from school

Name _____ Relationship _____ Phone: _____
Name _____ Relationship _____ Phone: _____
Name _____ Relationship _____ Phone: _____
Family Physician _____ City _____ Phone: _____
Choice of Hospital _____ Insurance Co. _____

Has child any drug/food/environmental/etc. allergies: _____
Any additional medical information: _____
List daily medications: _____ Date of latest TD _____

If any emergency arises, the school will try to contact the student's mother or father. If neither Parent can be reached, I give permission to Dr. _____
to be wholly responsible for the care of my child. If he is unavailable in the event of a major emergency, the administration is directed to seek emergency care at the medical
or hospital facility indicated above. I will be responsible for the payment of all expenses incurred.

Signature of Parent or Guardian _____ Date _____