St. Joseph School Emergency Information

School Year _____-_____

STUDENT'S NAME_____ **M F** _____-_____-_____
LAST **FIRST** **MIDDLE** **(Circle one)** **Student Date of Birth**

Father's Name_____ **Address**_____**Zip**_____

Home #_(_____)-_____ Cell #_(_____)-_____

Email Address:_____

Place of Employment_____ Work # _(_____)-_____

Mother's Name_____ **Address**_____**Zip**_____

Home #_(_____)-_____ Cell #_(_____)-_____

Email Address: _____

Place of Employment_____ Work # _(_____)-_____

EMERGENCY CONTACTS in the event that a parent/guardian cannot be reached:

Name_____ Address_____Phone_____

Relationship to student_____Cell #_____

Name_____ Address_____Phone_____

Relationship to student_____Cell #_____

EMERGENCY MEDICAL INFORMATION:

Physician_____ Address_____ Phone_____

Dentist _____ Address_____ Phone_____

ALLERGIES & OTHER MEDICAL CONDITIONS:

NO KNOWN MEDICAL CONCERNS _____ (please check that which applies & provide detailed information on the back of this card)

YES, THIS IS A CONCERN THE SCHOOL STAFF SHOULD BE AWARE OF: _____

In the event of emergency, I consent to have my child be given emergency care or medical treatment as needed until I can be reached. I will be responsible for medical costs incurred in the event of accidental injury.

Parent Signature_____ **Date**_____
