

STUDENT'S NAME (LAST, FIRST, MIDDLE) \_\_\_\_\_  MALE  FEMALE  
GRADE/ SECTION/ HOMEROOM TEACHER \_\_\_\_\_ DOB (mm/dd/yyyy) \_\_\_\_\_

HOME ADDRESS \_\_\_\_\_

CITY, STATE, ZIP \_\_\_\_\_

HOME PHONE \_\_\_\_\_ CUSTODY CONCERNS  YES  NO IF YES, CONTACT THE SCHOOL

MALE HEAD OF THE HOUSEHOLD \_\_\_\_\_  FATHER  GUARDIAN  OTHER

CELL PHONE \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

EMAIL \_\_\_\_\_

FEMALE HEAD OF THE HOUSEHOLD \_\_\_\_\_  MOTHER  GUARDIAN  OTHER

CELL PHONE \_\_\_\_\_ BUSINESS PHONE \_\_\_\_\_

EMAIL \_\_\_\_\_

### IF PARENT CANNOT BE REACHED, PERSON TO BE CONTACTED IN CASE OF EMERGENCY:

1. NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

2. NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

3. NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

### PERSON RESPONSIBLE FOR CHILD AFTER SCHOOL:

NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_

FAMILY PHYSICIAN'S NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

FAMILY DENTIST'S NAME \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

HOSPITAL PREFERENCE \_\_\_\_\_

DOES STUDENT HAVE A HEALTH CONDITION REQUIRING POSSIBLE EMERGENCY CARE?  YES  NO

IF YES, SPECIFY \_\_\_\_\_

IS STUDENT ON MEDICATION ON A CONTINUING BASIS?  YES  NO

IF YES, PLEASE LIST MEDICATION(S): \_\_\_\_\_

DOES STUDENT HAVE ALLERGIES?  YES  NO

IF YES, PLEASE LIST ALLERGIES: \_\_\_\_\_

I DO HEREBY AUTHORIZE BLESSED SACRAMENT SCHOOL TO OBTAIN EMERGENCY MEDICAL TREATMENT FOR THE HEALTH OF MY CHILD, \_\_\_\_\_ . I WILL NOT HOLD BLESSED SACRAMENT RESPONSIBLE FOR THE EMERGENCY CARE AND/OR EMERGENCY TRANSPORTATION FOR THE SAID STUDENT.

SIGNATURE \_\_\_\_\_