

Mother Teresa Academy – Emergency Information

School Year: _____

Student Name: .		
Grade:	Date of Birth:	Sex:
Student Street Address:	Mother's Name:	
City/Zip Code:	Mother's Cell Number:	Mother's Work Number:
Home Telephone Number:	Father's Name:	
Street Address is different from student?		Father's Work Number:
City/Zip Code:		Father's Cell Number:
Mother's Email:	Father's Email:	

IN THE EVENT OF AN EMERGENCY, IF YOU ARE UNABLE TO REACH ME, PLEASE CONTACT ONE OF THE FOLLOWING:

NAME: _____	NAME: _____
RELATIONSHIP: _____	RELATIONSHIP: _____
WORK PHONE: _____	WORK PHONE: _____
CELL PHONE: _____	CELL PHONE: _____

EMERGENCY MEDICAL INFORMATION:

Does the student have any allergies? _____
If yes, please describe: _____
Is the student currently taking any prescription medication? _____
If yes, please describe: _____
Any pertinent medical condition? _____
If yes, please describe: _____
Are there any dietary restrictions we should know about? _____
If yes, please describe: _____

X ____ (Initials) Emergency Medical Treatment

I (Parent or Guardian) give my consent to Mother Teresa Academy, its officers, agents employees, individuals associated with the organization or any emergency medical personnel to administer necessary treatment to my child (named above) in the event of an emergency and authorize transportation for child by ambulance if situation warrants. I agree to accept responsibility for the payment of the emergency treatment.

IF WE ARE UNABLE TO REACH YOU AT ANY OF THE ABOVE NUMBERS AND YOUR CHILD NEEDS TO BE TRANSPORTED TO THE EMERGENCY ROOM OF THE NEAREST HOSPITAL, YOUR SIGNATURE INDICATING PERMISSION FOR TREATMENT IS NECESSARY.

DOCTOR: _____ PHONE: _____

INSURANCE: _____ HOSPITAL PREFERENCE: _____

PARENT SIGNATURE: _____