St. Patrick SUCCEED Academy Emergency Information Form 2011-2012

Date_____ Student's Date of Birth _____ Grade___ Teacher_____

Student's Name_____
Last First Middle

Mailing Address**_____
Street City Zip Code

Who is the **primary person** to be contacted during school hours?
_____

Phone number 1: _____ **Phone number 2:**
_____

Student Living with ☐ Both Parents ☐ Father ☐ Mother ☐ Split Custody ☐ Guardian ☐ Other

If parents have split custody please explain who has custody and when (attach verification):

_____

_____

Father's Name _____
Last First Home ( )
Work ( )
Address _____ Cell ( )
Street City Zip

E-Mail Address_____

Employer _____
Name Job Title

_____
Address

Mother's Name _____
Last First Home ( )
Work ( )
Address _____ Cell ( )
Street City Zip

E-Mail Address_____

Employer _____
Name Job Title

_____
Address

In the event of apparent serious illness or accident, and I cannot be reached, I wish one of the following to be notified by telephone. They are authorized to act in my absence and will be informed that their names have been used on this form. (Please do not list Mother or Father in spaces below. It must be SOMEONE NEARBY who can be reached quickly.)

1.Name _____ Relationship _____ Hm# _____ Cell # _____

2.Name _____ Relationship _____ Hm# _____ Cell # _____

3. Name _____ Relationship _____ Hm# _____ Cell # _____

**** This is the address that will be used if it is necessary for the school to mail you any information.**

EXPLAIN ANY MEDICAL PROBLEMS THE SCHOOL SHOULD BE AWARE OF

_____

Allergies: _____

Known health conditions:

_____

Procedures to follow in case of this medical problem_____

_____

Physician's Name_____

Address_____ Phone _____

Insurance Medical Coverage _____

ID#_____Hospital Preference _____

Dentist's Name

_____

Address: _____ Phone: _____

Dental Coverage: _____

ID#_____

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

In the event of serious emergency, and none of the above named persons can be contacted, I authorize school officials to call my family doctor or, if the situation demands to transfer my child to nearest hospital for the necessary emergency care. I consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care, which is deemed advisable by, and is rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act on the Medical staff of a certified hospital, whether such diagnosis or treatment is rendered at the office of the physician or at the hospital. I **hereby agree to bear all costs incurred as a result of the foregoing:**

_____

Yes _____ No_____

(Please initial) _____

For the school year 2011-2012

_____

Signature of Parent/Guardian

Date