



# 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 \_\_\_\_\_

Parish Affiliation \_\_\_\_\_ Subdivision \_\_\_\_\_

**Please designate one E-mail address per household to be used for the Principal's Message and any necessary administrative communication.**

**Preferred E-mail Address** \_\_\_\_\_  Check box if any contact information has changed since the last school year.

**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