St. Elizabeth Catholic School
Emergency and Illness Information

Student's Name:_____Grade_____Date of Birth_____

Home Address:_____Phone_____

Father's Name:_____Cell Phone_____

Mother's Name:_____Cell Phone_____

***List the Phone Numbers to Call in Order of Preference:**

1st_____ 2nd_____ 3rd _____

Parent Work Information:

Place of Employment Father:_____Working Hours _____

Work Phone_____Work Email:_____

Place of Employment Mother:_____Working Hours_____

Work Phone_____Work Email:_____

Names of Persons to Contact if Parents are NOT available (2 CONTACTS-MUST BE COMPLETED)

1. Name:_____Address:_____

Relation to Student:_____Phone:_____Cell:_____

2. Name:_____Address:_____

Relation to Student:_____Phone:_____Cell:_____

Health Information:

Does your child have any NEW or unusual health conditions or **allergies**? _____Yes _____No

If **yes**, please explain**:** _____

_____

Physician/Dentist Information:

Family Doctor:_____Phone:_____

Dentist:_____Phone:_____

My child has permission to participate in the physical education program.

***If emergency treatment is required and you, the parents or legal guardians cannot be reached immediately, your signature in the spaces provided below empowers St. Elizabeth School authorities to exercise their own judgment in calling the physician indicated above or, if not available, to have the child transported to a local hospital emergency room.**

*Parent Signature:_____Date:_____

*Parent Signature:_____Date:_____

Date and initial yearly:

Updated_____Updated_____Updated_____
Updated_____Updated_____Updated_____
Updated_____Updated_____Updated_____