ST. THERESE SCHOOL, SUCCASUNNA, NJ
Family Emergency Information for 2020-2021

Dear Parents/Guardians:

Kindly fill in the following information for your children. This form will be kept on file in the school office. Please list only relatives or neighbors as “Backup Contacts” who are willing to pick up your child in case of illness or accident or are willing to take responsibility for your child in the rare instances of unscheduled dismissals, when you are not available. Please be sure that these neighbors or relatives are aware of their responsibility.

PLEASE PRINT CLEARLY AND COMPLETE ALL *REQUIRED FIELDS (specify “NONE” if inapplicable)

***STUDENT #1 NAME:**	**GRADE:**	**DATE OF BIRTH:**
STUDENT #2 NAME:	**GRADE:**	**DATE OF BIRTH:**
STUDENT #3 NAME:	**GRADE:**	**DATE OF BIRTH:**
STUDENT #4 NAME:	**GRADE:**	**DATE OF BIRTH:**
***STUDENT(S) STREET ADDRESS / CITY :**		
***PARENT/GUARDIAN #1 NAME:**	**PRIMARY PHONE NUMBER:**	**TYPE (HOME/OFFICE/CELL):**
	SECONDARY PHONE NUMBER:	**TYPE (HOME/OFFICE/CELL):**
PARENT/GUARDIAN #2 NAME:	**PRIMARY PHONE NUMBER:**	**TYPE (HOME/OFFICE/CELL:**
	SECONDARY PHONE NUMBER:	**TYPE (HOME/OFFICE/CELL):**
***BACKUP CONTACT #1 NAME:**	**PRIMARY PHONE NUMBER:**	**TYPE (HOME/OFFICE/CELL):**
***BACKUP CONTACT #2 NAME:**	**PRIMARY PHONE NUMBER:**	**TYPE (HOME/OFFICE/CELL):**
***PHYSICIAN NAME:**	**PHONE NUMBER:**	
***DENTIST NAME:**	**PHONE NUMBER:**	
***ALLERGIES:**		
***MEDICATIONS:**	***CHRONIC ILLNESS:**	
***DATE OF LAST TETANUS BOOSTER:**	***BEE STING REACTION? [Yes (specify Student Name) or No]**	***ASTHMA? [Yes (specify Student Name) or No]**
ADDITIONAL PERTINENT INFORMATION e.g. Surgeries, Operations, Other:		

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

This information will be kept in the possession of the school. Should the need arise, this information will be given to the proper medical authorities.
I understand that in the case of illness or injury to my child, the school will try to notify me or the person I have listed above as an emergency “backup” contact.
In case of medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to the school to:
1. arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic.
2. sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.
This Authorization for Emergency Medical Treatment is valid for a period of one year, from August 1st, 2020 until June 30th, 2021.

PARENT/GUARDIAN NAME (please print):

PARENT/GUARDIAN SIGNATURE: **DATE:**

Please print, complete, sign and return this response form to the school office on the first day of school, September 2, 2020.
This form MUST be remitted in original hard copy, not via email. Thank you for your cooperation.