

*Academy of Saint Therese*

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**Emergency Information Sheet**

**PLEASE PRINT ALL INFORMATION CLEARLY**

**Students Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_  
(First) (Last)

**Address:** \_\_\_\_\_ **Home Ph:** \_\_\_\_\_   
(Street) (City, State) (Zip)

→→→ Please indicate the calling order of your various phone numbers in the boxes following the numbers, e.g., if Home Ph # is first # to call during school hours, write "1" in the box.

**Custodial Parents/Guardians:** \_\_\_\_\_

**Father's Full Name:** \_\_\_\_\_ **Father's Occupation:** \_\_\_\_\_  
(First) (Last)

**Business Name/Address:** \_\_\_\_\_ **Father's Business Phone:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Father's Cell Phone:** \_\_\_\_\_

**Mother's Full Name:** \_\_\_\_\_ **Mother's Occupation:** \_\_\_\_\_  
(First) (Last)

**Business Name/Address:** \_\_\_\_\_ **Mother's Business Phone:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Mother's Cell Phone:** \_\_\_\_\_

**In case of emergency, the following adults are authorized and able to pick up my child (Note: parents will be contacted first)**

**#1 Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_  
(First) (Last)

**Address:** \_\_\_\_\_ **Other Phone #:** \_\_\_\_\_

**# 2 Name** \_\_\_\_\_ **Relationship:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_  
(First) (Last)

**Address** \_\_\_\_\_ **Other Phone #:** \_\_\_\_\_

**OVER →→→→→**

If a non-custodial parent is not included among those persons authorized by the custodial parent to pick up the student, please indicate below and attach a copy of appropriate legal documents (e.g., Court order).

Yes  No Non-custodial parent is NOT permitted to pick up student at any time unless authorized by custodial parent.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

Yes  No Legal documentation attached

**Physician Information:**

Name: \_\_\_\_\_ Practice: \_\_\_\_\_ Phone: \_\_\_\_\_  
(First) (Last)

Address: \_\_\_\_\_  
(Street) (City, State) (Zip)

**Dentist Information:**

Name: \_\_\_\_\_ Practice: \_\_\_\_\_ Phone: \_\_\_\_\_  
(First) (Last)

Address: \_\_\_\_\_  
(Street) (City, State) (Zip)

Hospital where student should be taken if parent of physician is not available (parent notification will immediately follow):

Name: \_\_\_\_\_ Locations: \_\_\_\_\_

Allergies, Medications and other medical conditions (list all): \_\_\_\_\_

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**NOTE: NON-PRESCRIPTION OR PRESCRIPTION DRUGS CAN BE ADMINISTERED ONLY WHEN ACCOMPANIES BY A DOCTOR'S ORDER**

I GIVE MY PERMISSION FOR THE NURSE TO SHARE MY CHILD'S MEDICAL INFORMATION WITH THE APPROPRIATE SCHOOL PERSONNEL ON A NEED TO KNOW BASIS.

\_\_\_\_\_  
Parent Signature Date

\_\_\_\_\_  
Please also Print Parent Name