



EMERGENCY/ILLNESS INFORMATION

PLEASE PRINT CLEARLY

1. _____
Student's Last Name *First Name* *MI* *DOB* *Grade*
Catholic: ___ Yes ___ No
___ African American ___ Asian ___ Caucasian ___ Hispanic ___ Native American ___ Other _____

2. _____
Student's Last Name *First Name* *MI* *DOB* *Grade*
Catholic: ___ Yes ___ No
___ African American ___ Asian ___ Caucasian ___ Hispanic ___ Native American ___ Other _____

3. _____
Student's Last Name *First Name* *MI* *DOB* *Grade*
Catholic: ___ Yes ___ No
___ African American ___ Asian ___ Caucasian ___ Hispanic ___ Native American ___ Other _____

4. _____
Student's Last Name *First Name* *MI* *DOB* *Grade*
Catholic: ___ Yes ___ No
___ African American ___ Asian ___ Caucasian ___ Hispanic ___ Native American ___ Other _____

Father's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____ Employer: _____ Work Phone: _____

Mother's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____ Employer: _____ Work Phone: _____

Legal Guardian's Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____ County: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Occupation: _____ Employer: _____ Work Phone: _____

OVER

Please list additional/local emergency contact who may take responsibility for/transport your child in a dismissal emergency if the school cannot contact parent/guardian.

Photo ID will be required for the person picking up students from school.

1. Name: _____ Relationship to Student: _____

Home: _____ Cell: _____ Work: _____

2. Name: _____ Relationship to Student: _____

Home: _____ Cell: _____ Work: _____

3. Name: _____ Relationship to Student: _____

Home: _____ Cell: _____ Work: _____

4. Name: _____ Relationship to Student: _____

Home: _____ Cell: _____ Work: _____

The following people DO NOT have permission to pick-up my child(ren) at any time, for any reason: (PLEASE PRINT CLEARLY)	
1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

Name of Student's Doctor/Practice: _____

Office Phone: _____

Health Insurance: _____ Member ID: _____

Name of Student's Dentist/Practice: _____

Office Phone: _____

Health Information: Does your child(ren) have any health conditions? If yes, please explain.

Release: If emergency treatment is needed and parents/legal guardians cannot be reached immediately, your signature in the space below empowers Sacred Heart Academy authorities to exercise their own judgement calling your physician/dentist listed above or if not available, to transport the child to a hospital or emergency room.

Parent/Guardian Signature

Date

Parent/Guardian Signature

Date

*If any information should change at any time during the school year **please** notify the Academy immediately. Thank you*