St. Michael-St. Gabriel the Archangel Catholic School

CONTACT AND EMERGENCY INFORMATION FORM

IDENTIFYING INFORMATION			EMERGENCY CONTACT INFORMATION		
Full Legal Name of Child:			***In the case of emergency or serious illness of my minor child, please attempt contact in the order listed below:***		
Birth date: *MM/DD/YYYY*	Grade:		**Call 1st:**	Name:	Home/Work Phone:
Parent (Guardian) Names:				Relationship:	Cell: Phone:
Address Street:			**Call 2nd:**	Name:	Home/Work: Phone:
Address Apartment No./Other:				Relationship:	Cell: Phone:
Address City:	State:	ZIP:	**Call 3rd:**	Name:	Home/Work: Phone:
Home Phone:	E-mail Address(es):			Relationship:	Cell: Phone:
Child lives with: ☐ Mother and Father ☐ Mother ☐ Father ☐ Grandparent(s) ☐ Guardian			Local Hospital of Choice:		
Who is the Custodial Parent (if applicable)?	☐ Custody Papers on file?		Physician of Choice:	Phone:	
Siblings attending this school:			**HEALTH INSURANCE INFORMATION**		
Adults authorized to pick up my child:	Name:	Phone No.	Company:	Co. Phone:	
			Policy Holder	Group No.:	
			Holder ID No.:	Plan No.:	
			Policy No.:	Patient (Child) ID No:	

MEDICAL INFORMATION

Child's Medical Condition(s):	Please list below any medical conditions your child has such as chronic or serious illness; severe allergies or sensitivities including, but not limited to: food, medicine, insects, or heat; asthma; cancer; diabetes, heart condition; respiratory problems; seizures, urinary problems; hemophilia; frequent hospitalizations; vision or hearing difficulties, physical limitations, etc. ☐ Individual Health Plan for chronic conditions on file (if applicable)	**Medications Taken Regularly by Child:**	Please list below any medications, treatments, or medical care your child receives on a regular basis that medical personnel may need to know about at the time of treatment for illness or injury. ☐ Medication Release on file for all medications taken at (*school, program, event, trip*)

CONSENT TO MEDICAL TREATMENT FOR A MINOR CHILD

I understand that in the case of a serious medical emergency, unless the injury/illness appears to be immediately life-threatening, the staff will make reasonable attempts to contact me/us as specified above *before* authorizing medical treatment. If I/we are not available to give consent, I/we hereby authorize the staff of St. Michael-St. Gabriel to act on my/our behalf, to call 911 emergency services, transport by ambulance, hospitalize; secure proper treatment; authorize injections, anesthesia, x-ray, surgery or other treatment for my child as deemed necessary by qualified medical personnel. I also understand that the medical information provided will be shared only on a medical "need-to-know" basis among staff and with treating medical personnel.

Notice is hereby given to qualified medical personnel that this authorization is currently in effect, and such personnel are directed to act upon this authorization without delay. I/we agree to assume financial responsibility for all expenses incurred in any emergency requiring medical attention.

Parent/Guardian Signature(s): **Relationship(s):** **Date:**