STUDENT EMERGENCY CONTACT CARD
Emergency Contacts/Medical Consent (other side)

In case of an emergency, it is imperative that the school be able to reach the student's parent or guardian. Please fill in the information on both sides of this card carefully and accurately. Please type or use ink and print clearly and legibly.

STUDENT ____ Male _______ Female _______ Grade _________
Last Name First Middle

____ Home Phone________________ Birthdate _________ Birthplace________________
Home Address (Primary Residence) City Zip

____ Lives with: Both Parents Mother Father Legal Guardian
Mailing Address, if different from above City Zip Address change? YES NO If Yes, please contact the school office.

MOTHER/GUARDIAN ______________________________ ______________________________|______________________________
Last Name First E-mail Employer
______________________________ ________________ | ________________ | ________________ | ________________
Home Address, if different from above City Zip Home Phone Work Phone Cell Phone Pager

FATHER/GUARDIAN ______________________________ ______________________________|______________________________
Last Name First E-mail Employer
______________________________ ________________ | ________________ | ________________ | ________________
Home Address, if different from above City Zip Home Phone Work Phone Cell Phone Pager
Are there any COURT-MANDATED custody/visitation orders limiting access to this student? YES NO **If Yes, please attach LEGAL ORDER.**

Other children at home: __________________________/_____/______________________ ______________________________/_____/________________
Name Grade School Name Grade School
Languages spoken at home: 1. ____ 2. ____

AUTHORIZED CONTACTS **Please list the names of relatives/neighbors/friends in close proximity to the school to whom we may release your child or contact if you cannot be reached. NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PARENTS, GUARDIANS OR ADULTS LISTED ON THIS CARD. In selecting someone to whom you authorize the release of your child, consider: (a) Would your child feel safe and comfortable with this person and family? (b) Could this person care for your child for several days? (c) Is this person prepared to handle any special medical needs required by your child?**

I/we hereby authorize the release of the student named above to the following persons in the event of illness, injury, evacuation or emergency that may occur while students are in school.

Name	Relationship	Home Phone	Work or Cell Phone
Out-of-state contact:			

I declare that the information on this form is true and correct. I will notify the school office immediately of any changes to be made in the foregoing information.

Parent/Guardian Signature____ Date ________________ Relationship________________________

Continued →

STUDENT EMERGENCY CONTACT CARD

Medical Information and Consent

STUDENT____

Last Name First Middle

MEDICAL/HEALTH INFORMATION

Medication: Does your child require medication? Yes No

If your child requires medication at school, all medication sent to school must be in the original prescription container with a current date and the child's name. An "Authorization for Administration of Medication" form must be on file.

Medication	Dosage	Hour(s) given

Health Insurance Information: Insurance Carrier Name: ______________________________

Health Plan/Group Name______________________ Policy No. ______________________

Physician/Health Care Provider______________________ Phone No. ______________________

Dentist______________________ Phone No.______________________

Vision and/or Hearing Problems:

Wears/glasses/contacts: for board work for reading all the time

Date of last eye exam______________________ Wears hearing aid(s)

Medical Conditions: Please circle if your child has any of the following:

Severe allergies requiring: Epi-pen Benadryl

Food/Environmental Stinging Insects/Bees Medicines/Drugs Other

Please explain:____

Current asthma If circled, uses inhaler on daily medication

Current seizures If circled, on medication? Yes No

Diabetes If circled, insulin dependent? Yes No

Behavior problems:____

Movement limitations:____

Other (please explain):____

Recent illness, hospitalization or surgery. If circled, please provide date(s) and description(s):

____

Medical condition which might require care or accommodation at school (please describe):

____

EMERGENCY TREATMENT AUTHORIZATION

I/we, the undersigned parent(s) or legal guardian of ______________________, a minor, do hereby give authorization and consent to the school to obtain emergency medical care and necessary transportation, including x-ray examination, anesthetic, medical or surgical diagnosis and emergency hospital which is deemed advisable by and is to be rendered under the general or specific supervision of medical and emergency room staff licensed under the provisions of the applicable laws of the State of Michigan.

It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the student, but that any of the above treatment will not be withheld if the undersigned or authorized adults cannot be reached.

______________________ is the hospital I/we prefer for emergency medical treatment of my/our child.

I/we understand that the school, parish or archdiocese does not provide accident/medical insurance for students, and I/we further understand that all costs related to medical treatment may be my/our responsibility and not that of the school, parish or archdiocese.

______________________ ______________

Parent/Guardian Signature Date

VOLUNTEER ASSISTANCE

If you live close to school and feel that, if called, you can offer volunteer assistance during an emergency, please provide your name, phone number and expertise.

I would like to help in an emergency.

______________________ ______________

Name Phone

____

Qualifications

REV 09/01/2008