

ST. JOSEPH PARISH SCHOOL EMERGENCY INFORMATION 2020-2021

PLEASE PRINT IN BLACK OR BLUE INK

FAMILY LAST NAME

First Names of Student(s) (From youngest to oldest attending St. Joseph Parish School only)	Grade in SY2020- 2021	Birthdate (mm/dd/year)	List any special health concerns including allergies to medication, food, insect bites, flowers, etc. <u>AND</u> describe the reaction to the allergen(s).
1.			
2.			
3.			
4.			

Student(s) live with: Both parents Mother Father Legal Guardian(s)

Primary Contact Number (cell /work/home) _____

Primary Contact Email Address _____

Home Telephone Number _____

Secondary Contact Email Address _____

Street Address _____

City _____

State _____

Zip Code _____

Mailing Address if different from above (include City, State, and Zip Code) _____

Name of Parish (if Catholic) _____

<input type="checkbox"/>	<p>Primary Contact</p> <p>First & Last Name of Father or Legal Guardian* _____</p> <p>Business Phone Number _____</p>	<p>Employer/Occupation _____</p> <p>Cell Phone Number _____</p>
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<input type="checkbox"/>	<p>Primary Contact</p> <p>First and Last Name of Mother or Legal Guardian* _____</p> <p>Business Phone Number _____</p>	<p>Employer/Occupation _____</p> <p>Cell Phone Number _____</p>
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***LEGAL DOCUMENTS AS LEGAL GUARDIAN MUST TO BE ON FILE**

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EMERGENCY CONTACTS In cases where my/our child(ren) is/are ill, injured, or in the event of an emergency closure of the school and I/we cannot be contacted, the school authorities have my/our permission to contact and release my/our child(ren) to the custody of one of the following people. (NOTE: These individuals may be required to present a valid picture ID).

1. _____
Name Relationship to child Home Number Work Number Cell Number

Street Address City State Zip Code

2. _____
Name Relationship to child Home Number Work Number Cell Number

Street Address City State Zip Code

I (we) understand that the school does not assume responsibility for payment of a physician in any case. Our choices of physicians are listed below with whom we give St. Joseph Parish School permission to contact. However, in the event of an emergency, I (we) authorize St. Joseph Parish School to call 911 which may require transportation by ambulance to the nearest hospital. I (we) also authorize any treatment recommended by the attending doctor. ALL EFFORTS WILL BE MADE TO CONTACT (PARENTS/GUARDIANS) FIRST UPON ANY EMERGENCY.

1. _____
Name of Physician Phone Number

2. _____
Name of Physician Phone Number

HEALTH INSURANCE INFORMATION

Medical Insurance Company (HMSA, KAISER, etc) Dental Insurance Company

No Medical Insurance No Dental Insurance

I/We understand that I/we must immediately inform the school of any changes to the information I/we have provided. By signing this form, I/we agree that this information is true and accurate to the best of our knowledge.

Father/Legal Guardian Name (please print) _____

Father/Legal Guardian Signature _____ Date _____

Mother/Legal Guardian Name (please print) _____

Mother/Legal Guardian Signature _____ Date _____