



# Emergency Information Saint Elizabeth Ann Seton Catholic School

The information below *must* be kept on file in the school office. Complete this form for each child and send it back to school tomorrow. Parents must complete this form prior to the start of the school year. PLEASE PRINT!

Parents are responsible for informing the office during the school year if changes in emergency information occur.

Name of Child \_\_\_\_\_ Grade \_\_\_\_\_

Name of Parent(s) or Legal Guardian(s) \_\_\_\_\_

Address \_\_\_\_\_ Preferred Phone \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Parent Place of Employment \_\_\_\_\_ Work Phone \_\_\_\_\_

**Who should we call if there is an emergency regarding this child, and in what order should we call them?**

**(This list should include parents & guardians)**

	Name	Relationship to Child	Phone Number(s)	Please check
1				<input type="checkbox"/> Cell phone <input type="checkbox"/> Home <input type="checkbox"/> Work
2				<input type="checkbox"/> Cell phone <input type="checkbox"/> Home <input type="checkbox"/> Work
3				<input type="checkbox"/> Cell phone <input type="checkbox"/> Home <input type="checkbox"/> Work
4				<input type="checkbox"/> Cell phone <input type="checkbox"/> Home <input type="checkbox"/> Work
5				<input type="checkbox"/> Cell phone <input type="checkbox"/> Home <input type="checkbox"/> Work

### CONSENT TO EMERGENCY CARE

In the event of an emergency, I request that the school make reasonable attempts to contact me at the above numbers or another parent/adult at the above listed numbers. I understand that in an emergency, difficult circumstances may prevent the school from contacting me immediately or the school may be unable to reach me. I therefore consent to the school's taking action which it deems necessary to secure emergency medical care/treatment for my child even if I have not been contacted.

I understand that decisions concerning the type of emergency medical care/treatment administered are made by health care providers and not by the school and that demanding circumstances may require the administration of emergency medical care or treatment without my prior consent. However, I have indicated below any treatment preferences I have for my child which the school may disclose to a health provider. (Check and complete any of the following)

\_\_\_\_\_ Dr. \_\_\_\_\_ is my preferred physician.

\_\_\_\_\_ Dr. \_\_\_\_\_ is my preferred dentist.

\_\_\_\_\_ Receipt of my consent prior to my child's receiving major surgery, unless the medical opinions of two licensed physicians or dentists concurring in the necessity for such surgery are obtained before surgery is performed.

The school may disclose the following checked information to a health care provider:

\_\_\_\_\_ Insurance Company: \_\_\_\_\_ Policy/Group/Claim # \_\_\_\_\_

\_\_\_\_\_ The following information regarding allergies my child has, medication my child is taking, and other medical facts about my child: \_\_\_\_\_

I understand that in the event of an emergency, the school will make reasonable efforts to notify a health care provider of the above-checked information; but I acknowledge that I am responsible for communicating such information to the appropriate medical personnel.

Date: \_\_\_\_\_ Signature of Parent/Guardian: \_\_\_\_\_