ST. JOHN PAUL II CATHOLIC SCHOOL – PAGE 1

CONTACT AND EMERGENCY INFORMATION FORM

IDENTIFYING INFORMATION		
Child(ren)'s Last Name:		
Child's First Name:	**Birthdate:**	**Grade:**
Child's First Name:	**Birthdate:**	**Grade:**
Child's First Name:	**Birthdate:**	**Grade:**
Child's First Name:	**Birthdate:**	**Grade:**
Mother's Name:	**Cell Phone:**	**Work Phone:** **Place of Work:**
Father's Name:	**Cell Phone:**	**Work Phone:** **Place of Work:**
Home Phone: **Address :**		
City:	**State:**	**Zip:**
Father's E-Mail: **Mother's E-Mail:**		
Child lives with: ☐ **Mother and Father** ☐ **Mother** ☐ **Father** ☐ **Grandparent(s)** ☐ **Guardian**		
Who is the Custodial Parent (if applicable)?	☐ **Custody Papers on file?**	
Address & Phone (If Different)		

Please complete all information and sign on Page 2.

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IN CASE OF EMERGENCY OR SERIOUS ILLNESS OF MY MINOR CHILD, IF I CANNOT BE REACHED PLEASE ATTEMPT TO CONTACT:

Name: **Home Phone:** **Cell Phone:**

Relationship to Child: **Work Phone:**

Name: **Home Phone:** **Cell Phone:**

Relationship to Child: **Work Phone:**

Name: **Home Phone:** **Cell Phone:**

Relationship to Child: **Work Phone:**

Local Hospital of Choice:

Physician of Choice:
Phone:

DISMISSAL PROCEDURE:

____Bus Rider/Bus #_____ ____Car Rider ____St. John Paul II Aftercare

Adults (other than parents/guardian listed on page 1) authorized to pick up my child from school:

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

Medical Information – Please list below any medical conditions your child has including severe allergies:

_____

_____

(Individual Health Plan for chronic conditions must be on file if applicable)

Medication Taken Regularly by Child:

_____

(Medication Release must be on file for all medications taken at school. Please see handbook.)

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. John Paul II Catholic School 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:**

Please complete all information and sign.