



St. Mary Catholic Middle School
Student Emergency Information
Please fill out form completely and print legibly.

Student Name: _____ **Nickname:** _____
Address: _____ **City/Zip:** _____
Home Phone: _____ **Lives with:** Mother / Father / Both / **Other:** _____
Birthdate: _____ **Gender:** Male / Female **Parish/City:** _____

Father Name: _____ **Mother Name:** _____
Address (if different): _____ **Address (if different):** _____
City/Zip: _____ **City/Zip:** _____
Home phone: _____ **Home phone:** _____
Cell phone: _____ **Cell phone:** _____
Employer: _____ **Employer:** _____
Work phone: _____ **Work phone:** _____
Email: _____ **Email:** _____

EMERGENCY CONTACT INFORMATION

List in preference, three people in the local area to contact if parents/guardians are not available in case of illness or emergency situation.

Name	Relationship	Phone (home, cell, or work)
1.		
2.		
3.		

Doctor:	Phone:
Dentist:	Phone:

In the event of a life-threatening situation, your child will be transferred to THEDA-CLARK Hospital or the closest hospital.

Does your child have any health conditions of which the school should be aware of? Include allergies and medications your child takes on a regular basis.

I hereby authorize treatment, administration of anesthesia and/or surgical treatments for my minor son/daughter, in the event of a medical situation occurring during my absence, when the hospital or physicians, nursing personnel employed by the hospital or physician, render such treatment necessary. I also authorize SMCMS faculty and/or staff to transport my child to the nearest facility in the case of an emergency.

Parent/Guardian Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

Insurance Company: _____ **Policy#:** _____

This emergency form is valid for the entire school year.