

# STUDENT EMERGENCY INFORMATION CARD

Archdiocese of Galveston-Houston

2025-2026 SCHOOL YEAR

STUDENT: \_\_\_\_\_  
(Last) (First) (MI) (Date of Birth) (Age) (Sex) (Grade)

FATHER/GUARDIAN NAME: \_\_\_\_\_

MOTHER/GUARDIAN NAME: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

EMAIL: \_\_\_\_\_

EMAIL: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

FATHER'S EMPLOYER: \_\_\_\_\_

MOTHER'S EMPLOYER: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

## LIST PERSONS TO BE CONTACTED IN CASE OF EMERGENCY WHEN PARENT/GUARDIAN CANNOT BE REACHED

### EMERGENCY CONTACTS

NAME: \_\_\_\_\_

NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_

PHONE: \_\_\_\_\_

EMAIL: \_\_\_\_\_

EMAIL: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

### MEDICAL INFORMATION

PHYSICIAN NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

DENTIST NAME: \_\_\_\_\_ PHONE: \_\_\_\_\_

INSURANCE CARRIER: \_\_\_\_\_

POLICY #: \_\_\_\_\_ GROUP#: \_\_\_\_\_

PREFERRED HOSPITAL: \_\_\_\_\_ PHONE: \_\_\_\_\_

ALLERGIES (drugs, food, environmental): \_\_\_\_\_

MEDICAL CONDITIONS (ie: diabetes, heart, etc.): \_\_\_\_\_

MEDICATION TAKEN DAILY TO REPORT TO EMT IN CASE OF AN EMERGENCY: \_\_\_\_\_

I, \_\_\_\_\_, do hereby authorize school administration to render first aid for illness or injury to my child named above. In the event of a medical emergency, I authorize school administration to have my child transported to the nearest hospital /emergency care center for emergency medical or surgical treatment and to contact my child's physician and any of the emergency contacts listed above. I further authorize the release of the above medical information to all medical personnel providing treatment. I agree to be solely responsible for the payment of all expenses incurred in such an emergency.

I do hereby release, hold harmless and indemnify the Most Reverend Daniel Cardinal DiNardo, of the Archdiocese of Galveston-Houston and his successors in office, the Diocese of Galveston-Houston, \_\_\_\_\_ School and any other of their officers, agents, employees or representatives ("Released Parties") from any and all liability, claims, losses or expenses arising from personal injury, death, or loss of or damage to property arising from any medical treatment received and/or transportation to the nearest hospital/emergency care center.

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