Holy Cross Catholic School

Student Emergency Information

In the case of an emergency involving your child, please help us contact you promptly by completing the information below.

Family Name: _____

Student Name: _____ M/F __ Date of Birth _____

Any special Health Conditions for this child *(Please include any allergies, concerns, regular medications, etc.*):*

_____

_____

Student Name: _____ M/F __ Date of Birth _____

Any special Health Conditions for this child *(Please include any allergies, concerns, regular medications, etc.*):*

_____

_____

Student Name: _____ M/F __ Date of Birth _____

Any special Health Conditions for this child *(Please include any allergies, concerns, regular medications, etc.*):*

_____

_____

Student Name: _____ M/F __ Date of Birth _____

Any special Health Conditions for this child *(Please include any allergies, concerns, regular medications, etc.*):*

_____

_____

** Please add additional children and health detail on the back of this form. Thank you!*

Who would you like us to <u>contact first</u> in the event of illness or emergency?

Parent/Guardian Name: _____ Relationship to child _____

Phone number(s) at which First Contact may be reached:

Cell _____ Home _____ Work _____

If the above-mentioned First Contact cannot be reached, please provide a second emergency contact person:

Name: _____ Relationship to child _____

Phone number at which Second Contact may be reached:

Cell _____ Home _____ Work _____

RESPONSIBLE ADULT(s) who have agreed to assume responsibility for your child(ren) if parent/guardian cannot be reached. These should be local and have the ability to transport the student:

NAME	RELATIONSHIP	ADDRESS	PHONE

PHYSICIAN OF CHOICE **ADDRESS** **PHONE**

_____

HOSPITAL OF CHOICE **ADDRESS** **PHONE**

_____

If you or responsible adult, as indicated above, cannot be reached in an emergency and, if in the judgment of school authorities immediate medical and/or hospital attention is indicated, do you **AUTHORIZE** responsible authorities to send your child (properly accompanied) to an available hospital or physician?

Yes_____ **No**_____

DATE: _____

SIGNATURE: _____

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