ST. JOHN THE APOSTLE CATHOLIC SCHOOL
est. 1844

2017-2018

Emergency & Extended Care Form

EMERGENCY INFORMATION

Family **Doctor**: ____________________
Phone: ___________________________
Family **Dentist**: ____________________
Phone: ___________________________
Medical **Insurance** Company:
____
Policy #: __________________________
Preferred **Hospital**: _________________
Phone: ___________________________

Normal Temperature: ______________
Chronic Illnesses: ___________________

Allergies, Medical Conditions or special needs that we should be aware of and required procedures:
____
____
____
____
____

Current Medications:
____
Date of last DPT Immunization:
____

STUDENT LIVES WITH:
○Both Parents ○Mother ○Father
○Joint Custody ○Stepfather ○Stepmother
○Guardian ○Foster Parents

Student's Full Name:____
Name to be used at school:____
Gender: M F Date of Birth:_____/_____/_____ Grade:________________

Primary Contact:_______________________Relationship _______________
Address:____
City, State, Zip:____
Cell Phone:______________________Home Phone:____________________
Employer:_______________________Wor kPhone:____________________
Employer Address:____

Second Contact:_______________________Relationship _______________
Address:____
City, State, Zip:____
Cell Phone:_______________________Home Phone:___________________
Employer:_______________________Work Phone:____________________
Employer Address:____

Third Contact:_______________________Relationship _________________
Address:____
City, State, Zip:____
Cell Phone:______________________Home Phone:____________________
Employer:_______________________Work Phone:____________________
Employer Address:____

People whom child may be released to, in addition to above contacts:

Name:_________________________________Phone:__________________
Name:_________________________________Phone: _________________
Name:_________________________________Phone:_________________
Name:_________________________________Phone: _________________
Name:_________________________________Phone: _________________

As a parent or legal guardian of the above listed child, I authorize both the SJA School Staff and the SJA Extended Care Staff to consent to any medical or surgical treatment of my child which such person deems advisable if I cannot reasonably be located, if my child is in need of treatment or transport to an emergency facility. Authorization is to be effective for the entire 2016-2017 school year.

Parent/Guardian Signature: ____ Date: ______________________________

Parent/Guardian Printed Name: ____