ST. JOHN
THE APOSTLE
CATHOLIC SCHOOL
est. 1844

Shadow Emergency Form

Please include $25 shadow fee, includes lunch at SJA

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:_____ Work Phone:_____
Employer Address:_____

Second Contact:_____ Relationship _____
Address:_____
City, State, Zip:_____
Cell Phone:_____ Home Phone:_____
Employer:_____Work Phone:_____
EmployerAddress:_____

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

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 Shadow visit.

Parent/Guardian Signature: _____ Date: _____

Parent/Guardian Printed Name: _____

516 Fifth Street | Oregon City OR | 97045 | Phone: 503.742.8230 | FAX: 503.742.8239 | www.sja-eagles.com