Blessed Trinity Catholic School Emergency Contact and Medical Information for a Child

Student Lives With: Both Parents_____ Father_____ Mother_____ Other (Whom) _____ **PLEASE PRINT**

Child's Name | Date of Birth | Grade | Sex M F

Parent's/Guardian's Name

( ) Home Phone ( ) Work Phone

Address

City, ST ZIP Code

Cell Phone ( )_____

Parent's/Guardian's Name

( ) Home Phone ( ) Work Phone

Address

City, ST ZIP Code

Cell Phone ( )_____

Alternative Emergency Contacts

Person to be contacted when parents cannot be reached: (Please inform person that they are listed as emergency contact.)

Primary Emergency Contact

( ) Home Phone ( ) Work Phone

( ) Cell Phone

Address

Secondary Emergency Contact

( ) Home Phone ( ) Work Phone

( ) Cell Phone

Address

Emergency Medical Information

Physician's Name | Clinic Name

Clinic Address | Phone Number

Insurance Company | Policy Number

Dentist's Name | Phone Number

Allergies/Special Health Considerations:_____

_____ Last DPT_____ Weight_____

*I give permission to Blessed Trinity Catholic School to make whatever emergency (e.g., first aid, disaster evacuation) measures are judged necessary for the care and protection of my child while under the supervision of the school.

**In case of medical emergency, I understand that my child will be transported to appropriate medical facility by the local emergency unit for treatment if the local emergency resource (Police, Rescue Squad) deems it necessary. The child will be transported at the expense of insurance or parents.

***It is understood that in some medical situations, the staff will need to contact the local emergency resource before the parent, child's physician, and/or other adult acting on the parent's behalf.

_____ Parent's Signature _____ Date