St. Joseph School
Student Shadow
Emergency Information Form

Student Name: _____ **Date of Birth:** _____ **Grade:** _____ **Gender:** ____

Student Address: _____

Home Phone: _____ **Email Address:** _____

Address: _____

Mother: _____ **Work Phone:** _____ **Employer:** _____
Cell Phone: _____

Father: _____ **Work Phone:** _____ **Employer:** _____
Cell Phone: _____

With whom does the child reside: _____ **Who has custody:** _____

Emergency Contact 1: _____

Emergency Contact 2: _____

Doctor: _____ **Dentist:** _____

List all Allergies: _____

List all Medications: _____

If emergency treatment is required and the parent or guardian listed above cannot be reached immediately, I request that the school exercise its own judgment in securing the health and safety of my child. Actions taken may include calling the physician and/or dentist listed above, calling 911 (giving permission to Medic 1 to administer medical attention, including medications and nursing care deemed necessary according to 911's contact/physician in charge) and transporting to the hospital listed above or to the nearest emergency center. I agree that, in the event of a disaster such as an earthquake, emergency medical services may be unavailable, and school staff may be the sole emergency medical providers.

_____ _____

Parent/Guardian Signature **Date**