

STUDENT EMERGENCY CARD
All Information MUST be filled out.
(This form must be completed every school year.)

Student's Name: _____
Date of Birth: _____ Grade: _____

Student's Name: _____
Date of Birth: _____ Grade: _____

Student's Name: _____
Date of Birth: _____ Grade: _____

Student's Name: _____
Date of Birth: _____ Grade: _____

Home Number: _____ E-Mail Address: _____

Mother/Guardians Name: _____

Work Phone: _____ Cell Phone: _____

Place of Employment: _____ Occupation: _____

Father/Guardians Name: _____

Work Phone: _____ Cell Phone: _____

Place of Employment: _____ Occupation: _____

Step Parent's Name (If Applicable): _____

Work Phone: _____ Cell Phone: _____

Place of Employment: _____ Occupation: _____

Child Resides with: _____

Complete Address: _____

Emergency Contacts: In case child/ren listed above becomes ill or injured at school and I cannot be contacted, the school authorities have my permission to contact and release my child to the custody at one of the following

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Those not permitted to remove child/ren from site (submit copy of court order)

Name: _____ Relation to Child: _____

Name: _____ Relation to Child: _____

Name: _____ Relation to Child: _____

The NCEA requests the following information for statistical purposes. Please circle all that apply.

Religion: Catholic Non Catholic

Ethnicity: Asian, American Indian/Native Alaskan, Black/African American, Hispanic, Native Hawaiian/Pacific Islander, White and Multi-racial

Student Emergency Card
All Information MUST be filled out
Page 2

If my child needs to be taken to an emergency facility, he/she will be taken to the nearest one. I give my consent for school authorities to take appropriate action for the safety and welfare of my child.

Student's Physician: _____ Phone: _____

Student's Dentist: _____ Phone: _____

Hospital Preference: _____

My child receives regular care for the following medical conditions:

___ No medical condition

___ Yes

Please check below:

___ Allergy ___ Bee Sting ___ Food ___ Medications ___ Other

List: _____

Date of Last reaction: _____

___ Asthma ___ Diabetes ___ Heart Disease ___ Sickle Cell Anemia ___ Cancer

___ Leukemia ___ Hearing Problem ___ Rheumatic Heart ___ Vision Problem

___ Chronic Cough ___ Wheezing ___ Hemophilia ___ Seizures ___ Glasses

___ Seizures ___ Glasses ___ Contacts ___ Takes medications ___ Other

List: _____

Date of Last Seizure/Surgery: _____

Is there any court order restricting access to the student or student's records ___ Yes, I will provide the school with a certified copy ___ No

To assure prompt attention to your child, PLEASE NOTIFY SCHOOL OF ANY CHANGE IN PHONE NUMBER OR ADDRESS

Parent/Guardian Signature

Date

**St. Patrick Catholic School
Emergency Permission Form
All information MUST be filled out**

To Whom It May Concern:

I hereby give my consent to any emergency facility and physician to administer treatment to my child/ren _____

In the event of an emergency at which time I cannot be reached, I give consent to transport by ambulance if the situations warrants it.

Hospital Preference: _____

Doctor Name: _____

My child/ren has health insurance _____ Yes _____ No _____

If Yes, what type: _____ Medicaid or Private _____

If private, print your plan information (Name, Address, Phone, Policy #):

State of Florida
County of Pinellas

On the _____ day of _____, 200__, before me came _____, to me known to be the individual described in and who executed the foregoing instrument and acknowledged that he/she executed the same.

Notary Public

Commission Stamp