

Student Emergency Card
All information MUST be filled out.
(This form must be updated annually.)

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

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Parish Affiliation _____

Student lives with: _____

Home Number: _____ E-Mail Address: _____

Mother/Guardian Name: _____

Place of Employment: _____ Number: _____

Occupation: _____ Cell # _____

Father/Guardian Name: _____

Place of Employment: _____ Number: _____

Occupation: _____ Cell # _____

Step Parent's Name: (If Applicable): _____

Place of Employment: _____ Number: _____

Occupation: _____ Cell # _____

Authorized Contacts: Please list the names of relatives/neighbor/friends to whom we may release your child or contact if you cannot be reached. NO STUDENT WILL BE RELEASED TO ANYONE OTHER THAN THE PARENTS, GUARDIANS OR ADULTS LISTED ON THIS CARD.

I/we hereby authorize the release of the student name above to the following persons in the event of illness, injury, evacuation or emergency that may occur while students are in school.

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: _____

I declare that the information on this form is true and correct. I will notify the school office immediately of any changes to be made in the foregoing information.

Parent/Guardian Signature: _____ Date: _____

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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/ren has health insurance ___ Yes ___ No
If yes, Health Plan/Group Name: _____
Address: _____
Policy Number: _____

My child receives regular care for the following medical conditions:
___ No medical conditions
___ Yes

Medical Conditions: Please check the appropriate boxes if your child has any of the following:
___ Severe allergies requiring: ___ Epi-pen ___ Benadryl ___ Latex ___ Medications
___ Food/Environmental ___ Stinging Insects/Bees ___ Other

Please explain: _____

___ Asthma If checked ___ uses inhaler ___ on daily medication
___ seizures If checked, on medication ___ Yes ___ No
___ Diabetes If checked, insulin dependent? ___ Yes ___ No

Behavior problems: _____

Movement limitations: _____

Other (please explain): _____

Any recent illness, hospitalization or surgery. Please provide date(s) and description(s):

Any medical condition which might require care or accommodation at school (please describe):

Vision and/or Hearing Problems:

___ Wears glasses/contacts: ___ for board work ___ for reading ___ all the time
Date of last eye exam _____

Emergency Treatment Authorization

I/we, the undersigned parent(s) or legal guardian of _____
a minor, born on _____, do hereby give authorization and consent
to St. Patrick Catholic School to obtain emergency medical treatment as the above name
might require while under the supervision of said care provider. I also agree to pay all
the costs and fees contingent on emergency medical care or treatment for this person as
secured or authorized under this consent.

State of Florida
County of Pinellas

On the _____ day of _____, 2012, 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