

**St. Elizabeth Catholic School
Emergency and Illness Information 2009-2010**

Important: Must Be Returned by September 4, 2009

Personal Data:

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

Home Address: _____ Phone _____

Father's Name: _____ Cell Phone _____

Mother's Name: _____ Cell Phone _____

***List the Phone Numbers to Call in Order of Preference:**

1st _____ 2nd _____ 3rd _____

Place of Employment:

Father: _____ Working Hours _____ Phone _____

Email: _____

Mother: _____ Working Hours _____ Phone _____

Email: _____

Names of Persons to Contact if Parents are NOT available (2 CONTACTS-MUST BE COMPLETED)

1. Name: _____ Address: _____

Relation to Student: _____ Phone: _____ Cell: _____

2. Name: _____ Address: _____

Relation to Student: _____ Phone: _____ Cell: _____

Health Information:

Does your child have any unusual health conditions or allergies? _____ Yes _____ No

If **yes**, please explain: _____

Physician/Dentist Information:

Family Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

My child has permission to participate in school field trips and in the physical education program.

***If emergency treatment is required and you, the parents or legal guardians cannot be reached immediately, your signature in the spaces provided below empowers St. Elizabeth School authorities to exercise their own judgment in calling the physician indicated above or, if not available, to have the child transported to a local hospital emergency room.**

*Parent Signature: _____ Date: _____

*Parent Signature: _____ Date: _____