

**St. Elizabeth Catholic School  
Emergency and Illness Information 2011-2012**

**Important: Must Be Returned by August 30, 2011 (First Day of School)**

**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:**

1<sup>st</sup> \_\_\_\_\_ 2<sup>nd</sup> \_\_\_\_\_ 3<sup>rd</sup> \_\_\_\_\_

**Parent Work Information:**

Place of Employment Father: \_\_\_\_\_ Working Hours \_\_\_\_\_

Work Phone \_\_\_\_\_ Work Email: \_\_\_\_\_

Place of Employment Mother: \_\_\_\_\_ Working Hours \_\_\_\_\_

Work Phone \_\_\_\_\_ Work 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: \_\_\_\_\_