Diocese of Fort Wayne – South Bend

Emergency Information

Our Lady of Hungary School

The information below *must* be kept on file in the school office. Complete this form for each child and send it back to school tomorrow. Parents must complete this form prior to the start of the school year. PLEASE PRINT!

Parents are responsible for informing the office during the school year if changes in emergency information occur.

Name of Child _____ Grade _____

Name of Parent(s) or Legal Guardian(s) _____

Address _____ Preferred Phone _____

City, State, Zip _____

Parent Place of Employment _____ Work Phone _____

Who should we call if there is an emergency regarding this child, and in what order should we call them?

(This list should include parents & guardians)

	Name	Relationship to Child	Phone Number(s)	Please check
1				____ Cell phone ____ Home ____ Work
2				____ Cell phone ____ Home ____ Work
3				____ Cell phone ____ Home ____ Work

CONSENT TO EMERGENCY CARE

In the event of an emergency, I request that the school make reasonable attempts to contact me at the above numbers or another parent/adult at the above listed numbers. I understand that in an emergency, difficult circumstances may prevent the school from contacting me immediately or the school may be unable to reach me. I therefore consent to the school's taking action which it deems necessary to secure emergency medical care/treatment for my child even if I have not been contacted.

I understand that decisions concerning the type of emergency medical care/treatment administered are made by health care providers and/or the school and that demanding circumstances may require the administration of emergency medical care or treatment without my prior consent. However, I have indicated below any treatment preferences I have for my child which the school may disclose to a health provider. (Check and complete any of the following)

_____ Dr. _____ is my preferred physician.

_____ Dr. _____ is my preferred dentist.

_____ My hospital of choice is _____

_____ Receipt of my consent prior to my child's receiving major surgery, unless the medical opinions of two licensed physicians or dentists concurring in the necessity for such surgery are obtained before surgery is performed.

_____ If my child's school has a prescription for auto-injectable epinephrine and my child is demonstrating signs or symptoms of life-threatening anaphylaxis during the school day, I DO NOT consent to the administration of auto-injectable epinephrine (epi-pen) for my child. .

The school may disclose the following checked information to a health care provider:

_____ Insurance Company: _____ Policy/Group/Claim # _____

_____ The following information regarding allergies my child has, medication my child is taking, and other medical facts about my child: _____

I understand that in the event of an emergency, the school will make reasonable efforts to notify a health care provider of the above-checked information; but I acknowledge that I am responsible for communicating such information to the appropriate medical personnel.

Date: _____ Signature of Parent/Guardian: _____

ADDITIONAL HOUSEHOLD INFORMATION

Child lives with (please circle):

Both Parents Mother Father Stepmother Stepfather Other _____

Full Time Shared Custody

Any additional information: _____

_____

_____

Your child departs most days with _____

I give permission for the following people to pick my child up from school on a semi regular bases:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

_____ YES, I give my child permission to depart their home campus at dismissal time without adult supervision via walking or riding a bicycle.

_____ NO, I do not give my child permission to depart their home campus at dismissal time without adult supervision via walking or riding a bicycle.

Parent / Guardian Signature: _____

E-mail Address _____ Family Parish _____

If your child attended public school, what elementary or middle school would (s)he attend?

_____

ADDITIONAL MEDICAL INFORMATION

Medication Taken _____ Dosage _____

Time Taken _____ Home or School (circle one)

** If medication needs to be taken at school, a CONSENT FOR ADMINISTRATION OF MEDICATION must be filled out and filed with the office. **

Allergies and / insect bite information:

_____

_____

Pertinent information regarding child's physical condition or medications:

_____

_____

Other important information:

_____

_____