CATHOLIC COMMUNITY OF OWOSSO
ST. JOSEPH / ST. PAUL HEALTH and EMERGENCY FORM
2016-2017

Student/Student's Name; (As printed on birth certificate)

_____
(Last) (First) (Middle Name)

_____
(Last) (First) (Middle Name)

_____
(Last) (First) (Middle Name)

_____
(Last) (First) (Middle Name)

MEDICAL ALERT

Medical Alert: Please list any known health conditions that your child's teacher or a health care provider should be aware of (Examples: allergic reactions to foods, drugs, or insect bites, asthma; diabetes; epilepsy, etc.).

Physician_____Phone_____

Hospital Preference, if possible_____

CHECK ONE OF THE BOXES AND SIGN

☐ In case of an emergency situation requiring professional care, I request treatment for my child until such time as I may be contacted.

Insurance Co._____Policy#_____Group#_____

☐ I request not medical treatment be given to my child and waive all claims for failure to provide these medical services.

_____ _____
Signature of Parent/Legal Guardian Date

PRIMARY EMERGENCY CONTACTS

In an emergency situation, all attempts will be made to contact one of the persons listed in this box as soon as possible.

Mother_____Phone_____ _____ _____
(Last) (First) (Home) (Work) (Cell)

Father_____ Phone_____ _____ _____
(Last) (First) (Home) (Work) (Cell)

Legal Guardian_____Phone_____ _____ _____
(Last) (First) (Home) (Work) (Cell)

If the program leader is unable to reach me or one of the other Primary Emergency Contacts, I hereby authorize contacting my Physician or one of the persons listed below to assume temporary care of my child in case of an emergency:

Name_____Phone_____ _____ _____
(Last) (First) (Home) (Work) (Cell)

Name_____Phone_____ _____ _____
(Last) (First) (Home) (Work) (Cell)

ADDITIONAL INFORMATION: Please provide **any** other information you feel would be beneficial to your child's teacher or a medical provider in an emergency situation.

_____