

**ST. AUGUSTINE CATHOLIC SCHOOL
STUDENT EMERGENCY INFORMATION FORM 2011-2012**

STUDENT NAME: _____
 (Last) (First) (MI) (Date of Birth) (Age) (Sex) (Grade)

Social Security Number: _____ Weight: _____ Height: _____ Baptized Catholic: **Yes / No**

Father/Guardian Name: _____ Mother/Guardian Name: _____

Address: _____ Address: _____
 (Street) (City/State) (Zip) (Street) (City/State) (Zip)

Home Phone: _____ Home Phone: _____

Father's Employer _____ Mother's Employer _____

Phone #'s: _____ Phone #'s: _____
 (Work) (Cell) (Work) (Cell)

Email Address(s): _____ Email Address(s): _____

Child lives with: Both Parents Father Mother Guardian(s)

Ethnic Background _____
(Ethnic backgrounds only include: White/Caucasian, African American, Hispanic, Asian, Multi Racial, Native American, Native Hawaii/Pacific Islander)

**LIST PERSONS TO BE CONTACTED IN CASE OF EMERGENCY
WHEN PARENT/GUARDIAN CANNOT BE REACHED OR ABLE TO PICK UP CHILD**

Contact Name	Telephone #'s	Relationship	Employer
_____	(Home) _____ (Work) _____ (Cell) _____	_____	_____
_____	(Home) _____ (Work) _____ (Cell) _____	_____	_____
_____	(Home) _____ (Work) _____ (Cell) _____	_____	_____

MEDICAL INFORMATION

DOCTOR'S NAME: _____ OFFICE #: _____ EMERGENCY #: _____

DENTIST'S NAME: _____ OFFICE #: _____ EMERGENCY #: _____

INSURANCE CARRIER: _____ GROUP/POLICY #: _____

ALLERGIES (drugs, food, environmental): _____

MEDICAL CONDITIONS (ex. diabetes): _____

MEDICATION TAKEN DAILY OR AS NEEDED (name, dosage & frequency): _____

DAILY MONITORING REQUIRED (glucose monitoring) _____

HOSPITAL PREFERENCE (EMS or other considerations will override parent preference) _____

ANY LIMITS ON PHYSICAL ACTIVITY? _____ WHY? _____

IS YOUR CHILD UNDER A PHYSICIAN'S CARE? _____ FOR WHAT CONDITION ? _____

Consent to Treat

I, _____, do hereby authorize school administration to render first aid for illness or injury to my child named above. In the event of a medical emergency, I authorize school administration to have my child transported to the nearest hospital /emergency care center for emergency medical or surgical treatment and to contact my child's physician and one of the persons listed above. I further authorize the release of the above medical information to all medical personnel providing treatment. I agree to be solely responsible for the payment of all expenses incurred in such an emergency.

I do hereby release, hold harmless and indemnify the Most Reverend Daniel DiNardo, Archbishop of the Archdiocese of Galveston-Houston and his successors in office, the Archdiocese of Galveston-Houston, St. Augustine Catholic School and any other of their officers, agents, employees or representatives ("Released Parties") from any and all liability, claims, losses or expenses arising from personal injury, death, or loss of or damage to property arising from any medical treatment received and/or transportation to the nearest hospital/emergency care center.

Signature of Parent/Guardian

Date Signed