ST. MATTHEW LUTHERAN SCHOOL EMERGENCY INFORMATION FORM

Student's Name_____ Date of Birth _____

Address_____ City_____ State _____ Zip_____

Home Phone #_____ Name of Parent(s)_____

List any pertinent health information, such as seizures, allergies (food, medications-penicillin etc.), diabetes, physical restrictions or other medical conditions that we should know about your child.

Any additional/special concerns that we need to be aware of:

PARENT CAN BE REACHED AT:

Mother: Name _____ Home Phone_____

Employer_____Work # _____ Cell #_____

Father: Name_____ Home Phone_____

Employer_____Work # _____ Cell #_____

PERSON TO BE NOTIFIED IN EMERGENCY SITUATION WHEN PARENT IS NOT AVAILABLE:

Name_____ Phone #_____ Cell #_____

Address_____ City_____State_____ Zip_____

Relationship_____

NAMES OF PERSONS OTHER THAN PARENT TO WHOM CHILD MAY BE RELEASED

Name_____Phone #_____ Cell #_____

Name_____Phone #_____ Cell #_____

Name_____Phone #_____ Cell #_____

Name_____Phone #_____ Cell #_____

PLEASE CONTINUE TO COMPLETE ON PAGE TWO OF THIS FORM

In case of an accident or serious illness, I hereby give permission to St. Matthew Lutheran School to secure emergency medical and/or emergency treatment for the above name minor child while in their care.
(non-emergency treatment is not included in this authorization)

Signature of Parent or Guardian_____ Date Signed_____

Doctor: Name_____ Phone #_____

Address_____ Emergency #_____

Parents should fill in the form below giving us information about the health and accident policy or policies carried by the family.

HEALTH INSURANCE POLICY NAME & NUMBER

HOSPTIAL PREFERRED FOR EMERGENCY TREATMENT

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