FRENCH AMERICAN INTERNATIONAL SCHOOL
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# NON-STAFF EMERGENCY INFORMATION FORM

## CONTACT INFORMATION

| | | | |
|---|---|---|---|
| LAST NAME: (NOM DE FAMILLE): | FIRST NAME (PRENOM): | NICKNAME (SURNOM): | Position: |
| Street Address: | City: | State/Zip | Birth Date (month/day/year): |
| Home Phone (land line only) : | Mobile: | Personal Email: | |

## EMERGENCY CONTACT INFORMATION 1

| | | | |
|---|---|---|---|
| LAST NAME: | FIRST NAME: | Gender (M/F): | Relationship |
| Street Address and City | State/Zip: | ADDRESS CORRECTION: | |
| Home Phone (land line only): | Work Phone: | PHONE CORRECTION: | |
| Mobile: | | ALT PHONE CORRECTION: | |
| Email: | | EMAIL CORRECTION : | |

## EMERGENCY CONTACT INFORMATION 2

| | | | |
|---|---|---|---|
| LAST NAME: | FIRST NAME: | Gender (M/F): | Relationship: |
| Street Address and City | State/Zip: | ADDRESS CORRECTION: | |
| Home Phone (land line only): | Work Phone: | PHONE CORRECTION: | |
| Mobile: | | MOBILE PHONE CORRECTION: | |
| Email: | | EMAIL CORRECTION: | |

By signing this form, I attest that all information on this form is correct to the best of my knowledge.

**SIGNATURE:** **DATE:**

## MEDICAL INFORMATION

| LAST NAME: | FIRST NAME: | |
|---|---|---|
| **ALLERGIES/MEDICAL CONDITION(S)** (PLEASE LIST THEM)**:** | | |
| | | |
| describe symptoms: | | |
| instructions for treatment: | | |
| **I HAVE PROVIDED FAIS WITH AN EPI-PEN AND AUTHORIZE CERTIFIED STAFF TO USE IT AS NECESSARY?** YES ☐ NO ☐ | | |

## PERMISSION TO TREAT

**EMERGENCY TREATMENT AUTHORIZATION** **Please read the following information carefully. Your signature is REQUIRED below.**

*In the event of acute illness or injury requiring emergency treatment, first aid will be administered and provision made to transport you to the nearest medical facility (Providence St. Vincent Medical Center), unless another facility is indicated. Every effort will be made by FAIS to reach the emergency or designated alternate on page 1.* **If you wish to authorize the school to apply an alternate provider please clearly indicate below. Check the appropriate item.**

☐ I authorize FAIS to act according to the above policy.
☐ I wish my emergency or alternate contact be called before any treatment is provided, unless in an extreme emergency.
☐ I authorize FAIS to transport me to the emergency facility designated below.*

| *preferred emergency medical facility | | emergency physician (if different from your regular physician): | |
|---|---|---|---|
| Name of physician: | phone: | specialist (e.g., allergist, dermatologist) | phone: |
| dentist: | phone: | other: | phone: |

**If FAIS is unable to reach the designated alternate, do you give FAIS permission to authorize the following medical emergency care?** (Please check **yes** or **no** in each category):

| Administer TYLENOL | X-RAY | Administer ANESTHETIC | EMERGENCY OPERATION |
|---|---|---|---|
| ☐ Yes | ☐ Yes | ☐ Yes | ☐ Yes |
| ☐ No | ☐ No | ☐ No | ☐ No |

I authorize FAIS to provide medical treatment in accordance with the information provided above. All information provided is correct to the best of my knowledge.

**SIGNATURE:** ..... **DATE:** ..... **PRINTED NAME:** .....

**Please return completed form to the appropriate FAIS department head.**
**Thank you!**