DIOCESE OF CHARLOTTE - MACS
STUDENT EMERGENCY INFORMATION
School Year 20___ - 20___

_____ ***SCHOOL*** **GRADE_____**

		LAST NAME	FIRST NAME
		HOME PHONE	PARISH ☐Non-Catholic
			DOB
ADDRESS	CITY	STATE	ZIP
MOTHER/GUARDIAN NAME	HOME PHONE	BUSINESS PHONE	CELL PHONE
FATHER/GUARDIAN NAME	HOME PHONE	BUSINESS PHONE	CELL PHONE
MOTHER'S E-MAIL ADDRESS:		FATHER'S E-MAIL ADDRESS:	

IN CASE OF EMERGENCY, IF A PARENT CANNOT BE REACHED PLEASE CONTACT:

1._____
NAME ADDRESS PHONE

2. _____
NAME ADDRESS PHONE

STUDENT'S PHYSICIAN	PHONE	STUDENT'S DENTIST	PHONE

ALLERGIES / MEDICAL CONDITIONS (Please explain checked items):

☐ Food Allergies _____ ☐ Medical Problems _____
☐ Insect Bite / Sting _____ ☐ Medications Taken at Home _____
☐ Drug Allergies _____

I give permission for my child, in case of an emergency, to be taken to a physician or hospital by either a parent in charge or by school personnel. I understand that every effort will be made to contact me. If I cannot be reached, I hereby give permission to the physician selected by the teacher in charge or adult chaperone to hospitalize and secure proper treatment (including surgery) for my son/daughter. I am the responsible party for physician/hospitalization payment.

SIGNATURE OF PARENT/GUARDIAN	DATE

SEE REVERSE SIDE

Please list those people who have permission to pick your child up from school:

1._____
NAME PHONE ***(home and cell)***

2._____
NAME PHONE ***(home and cell)***

3._____
NAME PHONE ***(home and cell)***

4._____
NAME PHONE ***(home and cell)***

Please describe your INCLEMENT WEATHER/CRISIS plan in case of early dismissal from school (include names and cell phone numbers if different from your emergency numbers).

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