

DIOCESE OF ALLENTOWN
Emergency Information 2024 - 2025
SCHOOL: OUR LADY OF PERPETUAL HELP

1. FAMILY INFORMATION

Student Name _____ Grade _____
Address _____ City _____ State _____ Zip _____
Home Telephone #(____) _____ Home E-Mail Address _____
Date of Birth _____ Place of Birth _____
Public School District _____ Bus Rider Walker Car Rider

2. PARENT/GUARDIAN INFORMATION

Student lives with: Parents Mother Father Other _____

Father's/Guardian's Name _____ Home Tel. # (____) _____
Employer _____ Work Tel. # (____) _____ (ext.) _____
Cell Tel. # (____) _____ Pager # _____ E-Mail _____
Mother's/Guardian's Name _____ Home Tel. # (____) _____
Employer _____ Work Tel. # (____) _____ (ext.) _____
Cell Tel. # (____) _____ Pager # _____ E-Mail _____

Parents/Guardians listed above have permission to pick up the child unless otherwise indicated. Notify the school principal immediately if there are any court orders restricting non-custodial parents or others from contact with the child. Provide the principal with a copy of the order.

3. CHILD CARE PROVIDER INFORMATION

Those designated below are authorized to pick up my child from school in an emergency:

Child Care Provider's Name _____ Relationship to Child _____
Home Tel. # (____) _____ Work Tel. # (____) _____ (ext.) _____
Cell Tel. # (____) _____ Pager # _____ E-Mail _____

4. LOCAL CONTACT INFORMATION

1. Local Contact's Name _____ Relationship to Child _____
Home Tel. # (____) _____ Work Tel. # (____) _____ (ext.) _____
Cell Tel. # (____) _____ Pager # _____ E-Mail _____
2. Local Contact's Name _____ Relationship to Child _____
Home Tel. # (____) _____ Work Tel. # (____) _____ (ext.) _____
Cell Tel. # (____) _____ Pager # _____ E-Mail _____

5. MEDICAL/PHYSICAL INFORMATION

Doctor's Name _____ Tel. # (____) _____
Hospital Preference _____ Second Choice _____
Insurance Company _____ Policy No. _____ Group No. _____
Dentist's Name _____ Tel. # (____) _____

In a medical emergency, we hereby authorize the school to seek emergency medical assistance for our child if we cannot be reached.

Parent/Guardian Signature

Parent/Guardian Signature

Date

Please keep a copy of this form for your records. IMPORTANT: Please update your school immediately if any information changes.

STUDENT HEALTH INFORMATION

Student's Name _____ Date of Birth _____

Grade/Teacher _____ / _____ Home Tel.#(____) _____

Does your child have a history of any of the following conditions? If so, please explain type of medical treatment.

YES NO

_____ _____ ADD/ADHD _____

_____ _____ Asthma _____

_____ _____ Diabetes _____

_____ _____ Food or Drug Allergy _____

_____ _____ Bee Sting Allergy _____

_____ _____ Seizure Disorder _____

_____ _____ Condition Limiting Physical Education _____

_____ _____ Migraine Headaches _____

_____ _____ Other Chronic or Recurrent Conditions _____

_____ _____ Glasses/Contacts (Please Circle) (When to be Worn) _____

_____ _____ Presently Taking Medications

Names of Medication

Reasons for Taking Medication

In the event that my child should become seriously ill or injured while in school and require prompt emergency care, I give my permission to the attending physician for any necessary emergency medical treatment.

Parent/Guardian Signature

Parent/Guardian Signature

Date

Please Print Name of Parent/Guardian Signature

Please Print Name of Parent/Guardian Signature

Date

Please List Siblings and Grades:
