Diocese of Rochester
Department of Catholic Schools
Emergency Treatment of Students

(please print all information)
Student Name_____ Birthdate_____

Grade_____ Teacher/Homeroom_____

Name of parent(s) or guardian(s) _____ Relationship to student _____

_____
(Home Address) *(Zip Code)* *(Home Phone)*

_____
(Father's Employment and Address) *(Work Phone)*

_____
(Mother's Employment and Address) *(Work Phone)*

Does your child have a chronic condition? Yes_____ No _____
If yes, specify _____

Is your child receiving any medication? Yes_____ No _____
If yes, specify _____

Is your child allergic to any medication? Yes_____ No _____
If yes, specify _____

In case my child meets with a serious accident at school and you are unable to contact me, you have my permission to take my child to this licensed health care professional:

Professional title and name _____

_____
(Address) *(Phone)*
or to _____Hospital.

If the name of the licensed health care professional is not supplied, you have my permission to take my child to the licensed health care professional on emergency call at the hospital stated above.

In case my child becomes ill while in school and you are unable to contact me, please contact:

Contact 1: Name of relative, friend or neighbor_____

Relationship to student _____

Address_____ Phone 1: _____ Phone 2: _____

Contact 2: Name of relative, friend or neighbor_____

Relationship to student _____

Address_____ Phone 1: _____ Phone 2: _____

Signature 1: *Parent/Guardian:* _____ *Date*_____

Signature 2: *Parent/Guardian:* _____ *Date*_____