



**Emergency Information**

**EMERGENCY CONTACT: I authorize the below named contact to authorize medical attention for my child(ren) and/or to pick up my child(ren) if I am not available.**

Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

Home Phone : ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone :( \_\_\_\_\_ ) \_\_\_\_\_

**Health Insurance Provider**

Insurance Provider: \_\_\_\_\_

Insurance Certificate Number: \_\_\_\_\_ Hospital Preference: \_\_\_\_\_

Parent Providing Coverage: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

**In the event that I or the family physician indicated above cannot be reached and if, in the judgment of the Parish staff, immediate medical attention is indicated, I authorize the Parish staff to send my child(ren) to an available hospital or physician. I authorize the treatment of my minor child(ren) by qualified emergency medical personnel or licensed medical doctors in the event of an emergency which, in the opinion of the attending emergency medical personnel and/or doctors, may cause physical disability, undue discomfort and/or endangerment of life if delayed. This consent is granted only after a reasonable effort has been made to reach me.**

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date \_\_\_\_\_

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**If there is a step-parent who you would like to have as a contact, put information below:**

Relationship to Child: \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/ZIP: \_\_\_\_\_ Home Phone: ( \_\_\_\_\_ ) \_\_\_\_\_

Email: \_\_\_\_\_

Religion: \_\_\_\_\_

May this parent pick up child(ren) from class? \_\_\_\_\_

Office use only: Date _____ Fee amount paid _____ Check # _____ Cash _____ Scrip: _____
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