EMERGENCY FORM - MOTHER SETON SCHOOL, EMMITSBURG, MD 2016-2017

INSTRUCTIONS TO PARENTS:

Complete side 1 & 2 - Please place N/A if does not apply - Please be sure to sign and date the form.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY. - PLEASE PRINT ALL INFORMATION UNLESS NOTED

STUDENT INFORMATION

CHILD'S GRADE _____

Child's Name _____ Birth Date _____
Last First

Child's Home Address _____
Street/Apt. # City State Zip

FATHER'S INFORMATION

Father's Name_____ Home Phone_____
Last First

Father's Employer/School_____
Name Address

Father's Home Address (if different from above) _____
Street/Apt # City State Zip

Work Phone_____ Cellular Phone_____ E-mail_____

MOTHER'S INFORMATION

Mother's Name_____ Home Phone_____
Last First

Mother's Employer/School_____
Name Address

Mother's Home Address (if different from above) _____
Street/Apt # City State Zip

Work Phone_____ Cellular Phone_____ E-mail_____

STEP PARENT/GUARDIAN INFORMATION

Step Parent/Guardian Name_____ Home Phone_____
Last First

Step Parent/Guardian Employer/School_____
Name Address

Step Parent/Guardian Home Address (if different from above) _____
Street/Apt # City State Zip

Work Phone_____ Cellular Phone_____ E-mail_____

AFTERNOON TRANSPORTATION INFORMATION

PLEASE CHECK AND LIST BUS NUMBERS

_____WALKER _____CAR RIDER _____BUS RIDER

MSS BUS (FREDERICK RUN) _____ MSS BUS (TANEYTOWN RUN) _____

WAYNESBORO BUS _____ GETTYSBURG BUS _____ FAIRFIELD BUS_____

TURN OVER FOR PAGE 2

EMERGENCY INFORMATION

IN CASE OF EMERGENCY, ILLNESS, OR ACCIDENT TO THE PUPIL AND IN THE EVENT THE PARENT/S CANNOT BE REACHED, PLEASE INDICATE BELOW THE NAME AND PHONE NUMBERS OF TWO PERSONS WHO COULD PICK UP AND TAKE HOME YOUR CHILD IN A TIMELY MANNER. THE SCHOOL IS AUTHORIZED TO PROCEED AS INDICATED BELOW. (PLEASE LIST AS 1,2 IN ORDER OF DESIRED CONTACT)

1. NAME_____ RELATION TO CHILD_____
   LAST FIRST

   HOME PHONE_____ CELL #_____ WORK #_____

2. NAME_____ RELATION TO CHILD_____
   LAST FIRST

   HOME PHONE_____ CELL #_____ WORK # _____

CHILD'S PHYSICIAN OR SOURCE OF HEALTH CARE_____PHONE #_____

CHILD'S DENTIST _____PHONE #_____

DOES YOUR CHILD HAVE SCHOOL INSURANCE _____YES _____NO

HEALTH INFORMATION

Complete the following items, as appropriate, if your child has a condition(s) of which you want us to be aware of.

Child's Name_____Birth Date_____

Medical Conditions(s)_____

_____

Medications currently being taken by your child _____

_____

Allergies/Reactions _____

Food Allergy_____ Medicine_____ Other_____
(PLEASE LIST WHAT YOUR CHILD IS ALLERGIC TO)

EMERGENCY MEDICAL INSTRUCTION (IF APPLICABLE)

1. Signs/symptoms to look for_____
2. If signs/symptoms appear, do this:_____
3. To prevent incidents:_____

In EMERGENCIES requiring immediate medical attention, your child will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at your child's school to have your child transported to the hospital. I hereby authorize its medical staff to provide treatment which a physician deems necessary for the well-being of my child.

PARENT/GUARDIAN SIGNATURE **DATE:_____**

_____ _____

Parent/Guardian (PLEASE PRINT) **Signature of Parent/Guardian** **7/16**