2024-2025 St. Ferdinand School Emergency Medical Contact Information Form
(PLEASE COMPLETE ONE FORM FOR EACH CHILD)

STUDENT'S NAME	GRADE	BIRTH DATE
HOME ADDRESS	HOME TELEPHONE NUMBER	
MOTHER'S NAME	MOTHER'S EMAIL	
MOTHER'S CELL PHONE	MOTHER'S WORK PHONE	
FATHER'S NAME	FATHER'S EMAIL	
FATHER'S CELL PHONE	FATHER'S WORK PHONE	

PLEASE CIRCLE:

Legal Custody: Both Parents Mother Only Father Only Other:_____

Child Lives With: Both Parents Mother Only Father Only Other:_____

LIST AT LEAST TWO PERSONS WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED:

Name:_____ Address:_____ Phone:_____

Name:_____ Address:_____ Phone:_____

Name:_____ Address:_____ Phone:_____

DOES YOUR CHILD HAVE ANY HEALTH PROBLEMS? (PLEASE CHECK)

Allergies? _____

Asthma? _____

Epilepsy/Seizures? _____

Heart Defect/Condition? _____

Vision/Hearing? _____

Does your child take medication? _____ Name of Medications(s): _____

Please note: If you child will need to take medication at school, please contact the School Office.

Is there any other health information that school personnel should know?_____

_____

I understand that the above information will be shared with pertinent school personnel only as needed. If parent/guardian cannot be contracted in case of serious illness, I authorize the school to take such emergency action as may be deemed necessary, including the transport to a hospital or medical center. As parent/guardian, I do herewith authorize the treatment of a qualified and licensed medical doctor of the above named minor in the event of a medical emergency which, in the opinion of an attending physician, may endanger his or her life, cause disfigurement, physical impairment of undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

_____

Signature of Mother / Legal Guardian Date

_____

Signature of Father / Legal Guardian Date