School Year 2019--2020

St. John's Catholic School
EMERGENCY INFORMATION

PLEASE PRINT OR TYPE

Student's Name: ______________________ **Home Phone:** ______________

Parent's Cell Phone(s): ______________________

Home Address: ____
Street City Zip

Parent or Guardian Name(s): ______________________________________

Work Information:

Mother's Work Phone: ____________ Work Hours: From ____________ To ____________

Father's Work Phone: ____________ Work Hours: From ____________ To ____________

Person to be called if Parents cannot be reached:

Name: ____
Relationship to Child

Phone Numbers: ____
Home Work Cell

Home Address: ____
Street City Zip

Doctor: ______________________ **Dentist:** ______________________

Address: ______________________ **Address:** ______________________

Phone: ______________________ **Phone:** ______________________

IN CASE OF SERIOUS INJURY AND IF NEITHER PARENT CAN BE CONTACTED, PERMISSION IS GIVEN TO ST. JOHN'S SCHOOL TO TAKE NECESSARY STEPS TO MAINTAIN THE HEALTH AND WELL BEING OF THE CHILD, AND THE PARENTS WILL ASSUME ALL FINANCIAL RESPONSIBILITY.

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DAY CARE INFORMATION

Will your child participate in after school care? Daily ____________ Occasionally ____________

Hours your child will generally be in Day Care: From ____________ To ____________

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PICK UP INFORMATION

Please list those persons who have your permission to pick up your child/children from St. John's School.

Name Relationship	Name Relationship	Name Relationship
Address	Address	Address
Phone Zip	Phone Zip	Phone Zip

Please complete and sign application. By your signature, you hereby certify that all your statements are true, correct and complete.

Signature: ______________________________ Date: ______________

Medical Information Sheet

Immunization: Please provide a copy of your Child's Immunization Record.

Verified by Health Department Record _____ Physician's Record _____ Other _____

Disease History: List the dates of each:

Measles ______________ **Mumps** ______________ **German Measles** ______________

Chicken Pox ______________ **Whooping Cough** ______________

Does your child have any special conditions that St. John's Staff should be aware of? (i.e. allergies, medical conditions, etc.) **Please list below.**

Frequent Ear Infection: Yes _____ No _____ **Frequent Throat Infection:** Yes _____ No _____

Defective Heart: Yes _____ No _____ **Contracted Tuberculosis:** Yes _____ No _____

Asthma: Yes _____ No _____

Allergies: ____

Current Medications: ____

Other Conditions or Comments: ____

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Consent to Administer Medication

I hereby **give** _________ (Yes) / **do not give** ____________ (No) the appropriate representative of St. John's School

permission to give my child medication as follows; e.g. over-the-counter medicine: ________________

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Signature: ______________________________ **Date:** ________________