



# Student Emergency Form

*For 2011-2012 School Year*

The faculty and staff at Immaculate Conception School make every attempt to properly care for your child (ren) in the event of sickness, accident, or any emergency. In order to assist us, please provide the following information requested and return this form to the school office during the first week of school.

STUDENT(S) LAST NAME: \_\_\_\_\_ FAMILY NAME: \_\_\_\_\_

Address: \_\_\_\_\_ City/State \_\_\_\_\_

(1 form only per family)

(if different)

Student(s) first name: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

Date of birth: \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_, \_\_\_\_\_

## PARENT(S) / GUARDIAN(S):

Name: \_\_\_\_\_ Home telephone: \_\_\_\_\_

Bus. Name: \_\_\_\_\_ Work telephone: \_\_\_\_\_

Relationship to student: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Home telephone: \_\_\_\_\_

Bus. Name: \_\_\_\_\_ Work telephone: \_\_\_\_\_

Relationship to student: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

## IN CASE OF AN EMERGENCY

Person to contact first: \_\_\_\_\_ Telephone: \_\_\_\_\_

Hospital to take student to: \_\_\_\_\_

Insurance Plan: \_\_\_\_\_

Doctor of student(s): Name \_\_\_\_\_ Telephone: \_\_\_\_\_

Dentist of student(s): Name \_\_\_\_\_ Telephone: \_\_\_\_\_

Please name **THREE** additional relatives or friends in the area who may be notified with whom your child (ren) may stay if no one is at home or if we cannot contact the person named above. **THESE PEOPLE MUST BE AWARE OF AND AGREE TO THIS RESPONSIBILITY.**

NAME	TELEPHONE	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____

In case of an accident the school personnel will attempt to reach the parent(s) / guardian(s). If necessary, the student will be sent to the emergency room of the hospital named above by ambulance or car (depending on the nature of the accident) for treatment. If you give the school authorities the right to act when you cannot be reached following an accident, please sign below.

Signature(s) of parent(s) / guardian(s): \_\_\_\_\_

*PLEASE COMPLETE THE BACK OF THIS FORM ALSO.*

Please give the following information for EACH child in your family who is a student at ICS. Please list the oldest first.

Examples of what should be included if applicable: Does the student wear glasses? Have a hearing disability? Take medication during school time? Take other medication which school personnel should know about? Have allergies? Have any other medical condition which the school personnel should be aware of?

1. Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Medical information:

2. Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Medical information:

3. Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Medical information:

4. Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Medical information:

**Students may not participate in any after school activities until all their Back to School Forms are returned to the office.**