

ST. AGNES SCHOOL

EMERGENCY INFORMATION AND MEDICAL TREATMENT CONSENT (To be completed by Parent)

_____ Family Name

1. _____ / _____ / _____ / _____
Name Grade Birthdate Lives with

2. _____ / _____ / _____ / _____
Name Grade Birthdate Lives with

3. _____ / _____ / _____ / _____
Name Grade Birthdate Lives with

4. _____ / _____ / _____ / _____
Name Grade Birthdate Lives with

Father's Name _____ Place of Employment _____
E-mail Address _____ Publish Y N
Address _____ Home Phone (_____) _____
City _____ State _____ Zip _____
Work # (_____) _____ Ext. _____ Pager # (_____) _____ Cell # (_____) _____
Mother's Name _____ Place of Employment _____
E-mail Address _____ Publish Y N
Address _____ Home Phone (_____) _____
City _____ State _____ Zip _____
Work # (_____) _____ Ext. _____ Pager # (_____) _____ Cell # (_____) _____

PERSONS TO CONTACT IF PARENTS ARE UNAVAILABLE:

**** WE NEED A MINIMUM OF THREE (3) EMERGENCY CONTACTS OUTSIDE OF THE HOME, PLEASE ! ****

1. _____ Home # (_____) _____ Work # (_____) _____ Relationship _____
2. _____ Home # (_____) _____ Work # (_____) _____ Relationship _____
3. _____ Home # (_____) _____ Work # (_____) _____ Relationship _____

EMERGENCY CONSENT & FERPA ACKNOWLEDGEMENT

I, _____ the parent or guardian of the above named student(s), recognize that emergency medical treatment may be necessary and further recognize that school personnel may be unable to contact me for my consent for emergency medical care. I do hereby consent in advance to such emergency care, including hospital care, as may be deemed necessary under the then existing circumstances.

Signature of Parent/Guardian

I hereby give permission for the confidential transfer of health & or school records to school personnel & other appropriate health professionals so that the best care can be provided for my child. I have been provided a copy of the Family Education Rights and Privacy Act (FERPA). _____ (see page 2 / over)

Signature of Parent/Guardian