



Seton Catholic Middle School Student Emergency Information

Please fill out form completely and print legibly.



Student Name: _____ Nickname: _____
 Address: _____ City/Zip: _____
 Home Phone: _____ Lives with (circle): Mother / Father / Both / Other: _____
 Birth date: _____ circle: male / female Parish/City: _____

Father Name: _____	Mother Name: _____
Address (if different): _____	Address (if different): _____
City/Zip: _____	City/Zip: _____
Home phone: _____	Home phone: _____
Cell phone: _____	Cell phone: _____
Employer: _____	Employer: _____
Work phone: _____	Work phone: _____
Email: _____	Email: _____

EMERGENCY CONTACT INFORMATION - List in preference, three people in the local area to contact if parents/guardians are not available in case of illness or emergency situation.

Name	Relationship	Phone (home, cell, or work)
1.		
2.		
3.		

Doctor	Phone
Dentist	Phone

In the event of a life-threatening situation, your child will be transferred to THEDA-CLARK Hospital or the closest hospital.

Does your child have any health conditions of which the school should be aware of? Include allergies and medications your child takes on a regular basis. _____

I hereby authorize treatment, administration of anesthesia and/or surgical treatments for my minor son/daughter, in the event of a medical situation occurring during my absence, when the hospital or physicians, nursing personnel employed by the hospital or physician, render such treatment necessary.

Signed this _____ day of _____, 2007.
 Valid through June 5, 2008.

Parent/Guardian Signature: _____

Parent/Guardian Signature: _____

Insurance Company: _____ Policy#: _____