

## STUDENT OR YOUTH EMERGENCY INFORMATION

PARISH/SCHOOL/DIOCESAN ENTITY: \_\_\_\_\_ CITY: \_\_\_\_\_

FAMILY NAME \_\_\_\_\_

Only ONE EMERGENCY INFORMATION form per family unit is necessary.

Full Name of Child	Sex	Date of Birth	Special Health Condition (describe) or Medication prescribed or Dietary needs, etc.

Home Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Name of Mother/Guardian: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Mother's work number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

Name of Father/Guardian: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

Father's work number: \_\_\_\_\_ Cell Number: \_\_\_\_\_

If divorced, name of legal custodial parent: \_\_\_\_\_

Do Mother and Father have Joint Custody? (Y/N) \_\_\_\_\_

If custodial parent cannot be reached, may we contact non-custodial parent? (Y/N) \_\_\_\_\_

RESPONSIBLE ADULT(s) who have agreed to assume responsibility for child, if parent/guardian cannot be reached.

Name	Address	Phone	Relationship to Child

Physician of Choice: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Hospital of Choice: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

If I, or responsible adult, and physician of choice, as indicated above, cannot be reached in an emergency and immediate medical and/or hospital attention is indicated I hereby authorize the transporting of my child to a hospital or physician for treatment.

Signature: \_\_\_\_\_

Print name: \_\_\_\_\_

Date: \_\_\_\_\_