

ST. SIMON OFFICE OF FAITH FORMATION
CONTACT AND EMERGENCY INFORMATION FORM

IDENTIFYING INFORMATION				EMERGENCY CONTACT INFORMATION				
Full Legal Name of Child:				<i>In the case of emergency or serious illness of my minor child, please attempt contact in the order listed below:</i>				
Birthdate:		Grade:						Call 1st:
Name of Child:				Call 2nd:	Relationship:		Cell Phone:	
Birthdate:		Grade:			Call 3rd:	Name:		Home Phone: Work Phone:
Address		City:	ZIP:	Relationship:		Cell Phone:		
Home phone:		Mom Cell:	Dad Cell:	Call 3rd:	Name:		Home Phone: Work Phone:	
E-mail:		E-mail			Relationship:		Cell Phone:	
Child lives with: <input type="checkbox"/> Mother and Father <input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Grandparent(s) <input type="checkbox"/> Guardian				Local Hospital of Choice:				
				Physician of Choice:		Phone:		
HEALTH INSURANCE INFORMATION								
Adults authorized to pick up my child:	Name:		Phone No.		Company:		Co. Phone:	
					Policy Holder		Group No.:	
					Holder ID No.:		Plan No.:	
					Policy No.:		Patient (Child) ID No:	
MEDICAL INFORMATION								
Child's Medical Conditions:	Please list below any medical conditions your child has such as chronic or serious illness; severe allergies or sensitivities including, but not limited to: food, medicine, insects, or heat; asthma; cancer; diabetes, heart condition; respiratory problems; seizures, urinary problems; hemophilia; frequent hospitalizations; vision or hearing difficulties, physical limitations, etc.				Medications Taken Regularly by Child:	Please list below any medications, treatments, or medical care your child receives on a regular basis that medical personnel may need to know about at the time of treatment for illness or injury.		
CONSENT TO MEDICAL TREATMENT FOR A MINOR CHILD								
<p>I understand that in the case of a serious medical emergency, unless the injury/illness appears to be immediately life-threatening, the staff will make reasonable attempts to contact me/us as specified above <i>before</i> authorizing medical treatment. If I/we are not available to give consent, I/we hereby authorize the staff of (<i>school, parish, or archdiocesan program</i>) to act on my/our behalf, to call 911 emergency services, transport by ambulance, hospitalize; secure proper treatment; authorize injections, anesthesia, x-ray, surgery or other treatment for my child as deemed necessary by qualified medical personnel. I also understand that the medical information provided will be shared only on a medical "need-to-know" basis among staff and with treating medical personnel.</p> <p>Notice is hereby given to qualified medical personnel that this authorization is currently in effect, and such personnel are directed to act upon this authorization without delay. I/we agree to assume financial responsibility for all expenses incurred in any emergency requiring medical attention.</p>								
Parent/Guardian Signature(s):				Relationship(s):		Date:		