ST. SIMON OFFICE OF FAITH FORMATION – 2017-2018
CONTACT AND EMERGENCY INFORMATION FORM

IDENTIFYING INFORMATION		
Birthdate:	Grade:	
Name of Child:		
Birthdate:	Grade:	
Address	City:	ZIP:
Home phone:	Mom Cell:	Dad Cell:
E-mail:	E-mail	
Child lives with: ☐ Mother and Father ☐ Mother ☐Father ☐ Grandparent(s) ☐ Guardian		

EMERGENCY CONTACT INFORMATION		
In the case of emergency or serious illness of my minor child, please attempt contact in the order listed below:		
Call 1st:	Name:	Home Phone: Work Phone:
	Relationship:	Cell Phone:
Call 2nd:	Name:	Home Phone: Work Phone:
	Relationship:	Cell Phone:
Call 3rd:	Name:	Home Phone: Work Phone:
	Relationship:	Cell Phone:
Local Hospital of Choice:		
Physician of Choice:	Phone:	

Adults authorized to pick up my child:	Name:	Phone No.

HEALTH INSURANCE INFORMATION	
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

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 *before* authorizing medical treatment. If I/we are not available to give consent, I/we hereby authorize the staff of (*school, parish, or archdiocesan program*) 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.

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.

Parent/Guardian Signature(s): **Relationship(s):** **Date:**