STUDENT / FAMILY EMERGENCY INFORMATION 2018-2019

FORM MUST BE ON FILE BY 8/22/18 (THE FIRST DAY OF SCHOOL)

Please *complete both sides* of this form. *Please Print Clearly!*

STUDENT LAST NAME: _____ **Primary Phone**: _____

Parent Primary Email Address: _____

Student's Name(s) & Grade(s) _____

Street Address: _____ City: _____ State: _____ Zip: _____

Parish_____ ☐ **non-Catholic**

Mother/Guardian Name: _____ Home Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Work Place: _____ Do you own this business? YES NO Matching Gifts? YES NO

Work Number: _____ Cell Phone: _____

Mother/Guardian Email: _____

Father/Guardian Name: _____ Home Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Work Place: _____ Do you own this business? YES NO Matching Gifts? YES NO

Work Number: _____ Cell Phone: _____

Father/Guardian Email: _____

In Case of Emergency, Contact: (other than parents)

1._____
NAME PHONES (Home, Cell, Work)

2._____
NAME PHONES (Home, Cell, Work)

Please list those people who have permission to pick your child up from school:

1._____
NAME PHONES (Home, Cell, Work)

2._____
NAME PHONES (Home, Cell, Work)

Please describe below your **INCLEMENT WEATHER/ CRISIS** plan in case of early dismissal from school. (Include names and phone numbers if different from your emergency numbers).

PLEASE COMPLETE *MEDICAL / INSURANCE INFORMATION*

☞FOR *EACH* STUDENT ON THE BACK OF THIS FORM.☜

BMHS FORM ***Form is not complete without this information or signed by a parent!***

1. **STUDENT'S NAME: _____ GRADE: _____ DOB_____**

Allergies/Medical Conditions: Please check all that apply & Explain

__Food Allergies _____ __Diabetes_____ Other (please explain) _____

__Drug Allergies _____ __Epilepsy_____ _____

__Insect Bite / Sting _____ __Heart Problems_____ _____

__Prescription Medications Taken at Home _____

(Prescription/non-Prescription Medication Form must be signed by parents & physician & on file to administer any medications)

Student's Physician: _____ Phone: _____ Dentist: _____ Phone: _____

Hospital where child should be taken in emergency: _____

Insurance Name: _____ Policy #: _____ Policy Period: _____

2. **STUDENT'S NAME: _____ GRADE: _____ DOB_____**

Allergies/Medical Conditions: Please check all that apply & Explain

__Food Allergies _____ __Diabetes_____ Other (please explain) _____

__Drug Allergies _____ __Epilepsy_____ _____

__Insect Bite / Sting _____ __Heart Problems_____ _____

__Prescription Medications Taken at Home _____

(Prescription/non-Prescription Medication Form must be signed by parents & physician & on file to administer any medications)

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Hospital where child should be taken in emergency: _____

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3. **STUDENT'S NAME: _____ GRADE: _____ DOB_____**

Allergies/Medical Conditions: Please check all that apply & Explain

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__Drug Allergies _____ __Epilepsy_____ _____

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(Prescription/non-Prescription Medication Form must be signed by parents & physician & on file to administer any medications)

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4. **STUDENT'S NAME: _____ GRADE: _____ DOB_____**

Allergies/Medical Conditions: Please check all that apply & Explain

__Food Allergies _____ __Diabetes_____ Other (please explain) _____

__Drug Allergies _____ __Epilepsy_____ _____

__Insect Bite / Sting _____ __Heart Problems_____ _____

__Prescription Medications Taken at Home _____

(Prescription/non-Prescription Medication Form must be signed by parents & physician & on file to administer any medications)

Student's Physician: _____ Phone: _____ Dentist: _____ Phone: _____

Hospital where child should be taken in emergency: _____

Insurance Name: _____ Policy #: _____ Policy Period: _____

PARENT/GUARDIAN SIGNATURE REQUIRED:

Should your student be injured while in school or while involved in any school activity, your insurance company would be considered the primary insurer and the school's insurer would be secondary. In the absence of primary coverage, the school's insurance company would serve as the primary carrier.

I give permission for my child(ren), in case of an emergency, to be taken to a physician or hospital by either school personnel or an adult chaperone. I understand that every effort will be made to contact me. If I cannot be reached, I hereby give my permission to the physician selected by the teacher in charge or adult chaperone to hospitalize and secure proper treatment (including surgery) for my son/daughter. I am the responsible party for physician/hospitalization payment.

Signature of Parent/Guardian **Date**

☝FORM MUST BE SIGNED ABOVE ☝