Good Shepherd Network of Catholic Schools

2013 – 2014 Student Emergency/Health Information

Applications must be filled out completely to complete the registration process.
An Emergency Information form must be filled out for EACH child.
[Please Print Clearly]

Student Information

Last Name: __________________________ First Name: ________________________ DOB: ___________ Grade: _________

Street Address: ____ City: ___________________________ Zip: _________

Home Phone: _____________________________ Gender (circle one): Male or Female

Parental/Guardian Information

Mother's Name: ____ Work: _________________ Cell: _________________

Father's Name: ____ Work: _________________ Cell: _________________

Emergency Contacts

In case of emergency in which the parents cannot be reached & the following people may pickup my child from this school:

Last: _______________________ First: ________________________ Relation: ________________ Phone: _______________

Last: _______________________ First: ________________________ Relation: ________________ Phone: _______________

Last: _______________________ First: ________________________ Relation: ________________ Phone: _______________

Last: _______________________ First: ________________________ Relation: ________________ Phone: _______________

Last: _______________________ First: ________________________ Relation: ________________ Phone: _______________

Health Information

1. List health conditions such as heart disease, diabetes, epilepsy, asthma, eye/ear problems, blood pressure abnormalities, severe food/drug allergies, etc. A note from your child's physician is required for heart conditions, diabetes, epilepsy/seizures, or asthma with use of inhaler.

____

____

2. Is there any need for medication or inhalers at school? If so, list medication to be taken or kept at school?

____

____

3. Are there any special concerns or limitations regarding athletic participation for your child?

____

____

Consent To Treat

I, the undersigned, do hereby authorize the officials of the Good Shepherd Network of Catholic Schools to contact directly the person named on this form, and do authorize the name physicians to render such treatments may be deemed necessary in an emergency for the health of said child.

In the event physicians, other persons named on this card, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of the aforesaid child.

I will not hold the Good Shepherd Network of Catholic Schools financially responsible for the emergency care and/or transportation for said child.

____
Please Print Parent Name

____ _________________
Parent Signature Date

Physician: ___________________________________ Physician Phone: ____________________

Address: ____________________________________ City: _______________________________________ Zip: _________

Local Hospital: ______________________________ Address: ____________________________ City: _____________

Insurance Company Name: ____________________ Policy No.: ____