



HOLY CHILDHOOD SCHOOL – 2016 - 2017
EMERGENCY INFORMATION

Home Phone: _____

Name: _____ Grade: (2016-17) _____

Male _____ Female _____

Mailing Address: _____ City: _____ Zip: _____

E-Mail (Mom): _____ E-Mail (Dad): _____

Student's Birthday: _____

Mother's Name: _____ Cell Phone: _____

Work Number: _____ Place: _____

Father's Name: _____ Cell Phone: _____

Work Number: _____ Place: _____

Child resides with: _____ Parents _____ Mother _____
(Name) Father _____ Legal Guardian _____

If your child becomes ill during the school day, who should we call first? If it's you, list yourself first.

1. Name _____ Number _____

2. Name _____ Number _____

3. Name _____ Number _____

Does your child have any allergies? _____
(Please be sure to submit all required medical forms for inhalers, epipens and other medications.)

Does your child have any vision, hearing, or other concerns we should know about?

Is your child Catholic? _____ If not, what religion/Church? _____

Are you a registered member of Holy Childhood Parish? _____

Are you active military? _____

If there is an emergency and you cannot be reached, who is your family doctor?

Name _____ Number _____

Emergency Hospital _____ Number _____

In case of an accident or serious illness, if I cannot be reached at the above address, Holy Childhood School has my permission to call an ambulance and seek medical attention for my child.

Parent Signature