

**ST. PHILIP NERI SCHOOL – 2009/20010 EMERGENCY CARD**

PLEASE PRINT & USE PENCIL

Student's Name \_\_\_\_\_ Grade \_\_\_\_\_ Birth Date \_\_\_\_\_

Parent OR Guardian Name(s) \_\_\_\_\_ Home Phone # \_\_\_\_\_

Home Address \_\_\_\_\_

Father's Business & Address \_\_\_\_\_ Phone # \_\_\_\_\_

Mother's Business & Address \_\_\_\_\_ Phone # \_\_\_\_\_

Father's Cell Phone # \_\_\_\_\_ Mother's Cell Phone # \_\_\_\_\_ Pager # \_\_\_\_\_

Names of all adults living in household who can assume responsibility for your child: 1) \_\_\_\_\_

2) \_\_\_\_\_ 3) \_\_\_\_\_ 4) \_\_\_\_\_

In case of emergency or illness, if parents are not available, list 2 persons WITH TRANSPORTATION who will be available and willing to assume temporary care of your child. Please make sure these people know that you have used their name and telephone number for an emergency.

Name	Relationship	Home Phone	Cell Phone
_____	_____	_____	_____
_____	_____	_____	_____

Name	Relationship	Home Phone	Cell Phone
_____	_____	_____	_____

Directions to your home: \_\_\_\_\_

\_\_\_\_\_  
(OVER—)

If emergency treatment is required, may the school authorities use their own judgment in sending your child to the hospital or doctor most easily accessible providing none of the above listed people can be reached? Yes \_\_\_\_\_ No \_\_\_\_\_

If NO – Name of Local Preferred Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Hospital Preferred \_\_\_\_\_

Local Dentist \_\_\_\_\_ Phone # \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

My child has the following health problems and/or allergies: \_\_\_\_\_

We agree to assume all responsibility and expenses incurred by the handling of this emergency case unless the emergency is covered by school insurance.

Insurance: \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_

**DAY CARE INFORMATION**

Please complete the following information concerning Day Care.

Name of facility \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_

Day of Care: M T W T F