**Lumen Christi Catholic School** **2019-20 School Year**

# Emergency Contact and Medical Information

Child's Name | Date of Birth | M F Sex

Parent's/Guardian's Name | Parent's/Guardian's Name

( ) Home Phone | ( ) Work Phone | ( ) Home Phone | ( ) Work Phone

Address | Address

City, ST ZIP Code | City, ST ZIP Code

## Alternative Emergency Contacts

Primary Emergency Contact | Secondary Emergency Contact

( ) Home Phone | ( ) Work Phone | ( ) Home Phone | ( ) Work Phone

Address | Address

City, ST ZIP Code | City, ST ZIP Code

## Medical Information

Hospital/Clinic Preference

Physician's Name | Phone Number

Insurance Company | Policy Number

Allergies/Special Health Considerations

By signing below, I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the even that neither parent/guardian can be reached in the case of an emergency.

When medication absolutely must be taken by an elementary school child during the school day, parents (guardians) shall provide explicit written instructions, including instructions as necessary from their physician or other medical practitioner regarding the need for medication or specific medical care.

By signing below, I also give permission for non-medically trained school personnel to oversee such self-administration of medication, if applicable, and to provide other routine medical care as necessary during the school day.

Parent's/Guardian's Signature | Date

## Immunizations

Please **check** the appropriate line.

- My child(ren) receives regularly scheduled immunizations. _______
- My child(ren) does **NOT** receive a regular schedule of immunizations. _____ Please attach a letter stating the reason.

Parent's/Guardian's Signature | Date