

TRENTON CATHOLIC ACADEMY EMERGENCY & ILLNESS INFORMATION

Student's Name: _____ Grade: _____ Date of Birth: _____ Today's Date: _____
Home Address : _____ City: _____ State: _____ Zip: _____
Ethnic Background: _____

*Parent/Guardian: _____
Home#: _____ Cell#: _____ Work#: _____
Email Address _____

*Parent/Guardian: _____
Home#: _____ Cell#: _____ Work#: _____
Email Address _____

Emergency Contact Information **List responsible adult who will assume temporary care of your child in the event a parent/guardian can't be reached.**

*Name/Relationship _____ Cell#: _____ Work#: _____
Home#: _____

Medical Information

Physician's Name: _____ Telephone #: _____
Allergies or medical conditions: _____
Does your child require any daily medication? _____
If so, please explain _____
Family Dentist: _____ Telephone#: _____

Release

If emergency treatment is required, and the parents or legal guardian cannot be reached immediately, your signature in the space provided below empowers the school authorities to exercise their own judgment in calling the physician indicated above, or if not available, to transport the child to a hospital emergency room. Likewise, your signature below is not sufficient for the release of confidential information protected by Federal Law.

Parent Signature: _____ Date: _____