

SAINT JOHN SCHOOL STUDENT EMERGENCY CONTACT INFORMATION

Please complete and either email completed form to nurse@saintjohnschoolos.org
or fax printed form to 860-388-6265 or mail to Saint John School

FAMILY LAST NAME: _____

ADDRESS: _____

1. Name: _____ DOB: _____ Grade: _____

Allergies: _____

2. Name: _____ DOB: _____ Grade: _____

Allergies: _____

3. Name: _____ DOB: _____ Grade: _____

Allergies: _____

4. Name: _____ DOB: _____ Grade: _____

Allergies: _____

Parent/Guardian Information Please place "M" by phone # for medical issues during school

	Parent/Guardian 1	Parent/Guardian 2	Parent/Guardian 3
Name			
Relationship			
Lives with Child			
Home Phone			
Cell Phone			
Work Phone			
Employer			
Email			

Emergency contact will be called ONLY after attempting to contact Parents/Guardians

Emergency Contact (Not Parent or Guardian)	
Name	
Relation to Student	
Best Phone to Reach	

Student's Physician

Name:	Phone:
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Student's Dentist

Name:	Phone:
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I authorize the contacts listed above to discuss health matters with the school nursing staff and make health care decisions. **Yes** _____ **No** _____

In the event of a serious medical emergency or accident, and I cannot be reached, I authorize the school personnel to have my child treated by a readily available physician, hospital or emergency facility. **Yes** _____ **No** _____

Parent/Legal Guardian Signature: _____ **Date:** _____