St. Anthony School
Hawthorne, NJ

EMERGENCY INFORMATION FORM

School Year: 2020-2021

Dear Parent/Guardian:

Please complete the following information for each of your children.

STUDENT INFORMATION:

Child's Name: _____ _____ Grade _____ D.O.B. _____
Last First

Child's Name: _____ _____ Grade _____ D.O.B. _____
Last First

Child's Name: _____ _____ Grade _____ D.O.B. _____
Last First

Home Address:_____ City _____ Zip Code_____

Home Phone # _____

PARENT/GUARDIAN INFORMATION:

Father's Name: _____ _____ Cell #_____
Last First

Work #_____ E-mail Address: _____

Mother's Name:_____ _____ Cell #_____
Last First

Work #_____ E-mail Address: _____

PERSONS AUTHORIZED TO PICK UP YOUR CHILD(REN):

Name: _____ Relationship:_____

Home Phone # _____ Cell Phone #_____

Name: _____ Relationship:_____

Home Phone # _____ Cell Phone #_____

PLEASE COMPLETE REVERSE SIDE OF FORM

MEDICAL EMERGENCY INFORMATION:

Child's Name: _____

Medical Alert: Seizure disorder_____ Asthma _____ Other_____

Diabetes _____ Allergies _____

Medications: _____

Child's Name: _____

Medical Alert: Seizure disorder_____ Asthma _____ Other_____

Diabetes _____ Allergies _____

Medications: _____

Child's Name: _____

Medical Alert: Seizure disorder_____ Asthma _____ Other_____

Diabete _____ Allergies _____

Medications: _____

May health information be shared with staff? Yes_____ No_____

May health information be requested from Physician? Yes_____ No_____

List two neighbors or relatives who will assume temporary care of your child due to illness during school hours if you cannot be contacted:

Name_____ Relationship _____Phone_____

Name_____ Relationship_____Phone_____

In case of accident or serious illness, I request the school to contact me. If unable to reach me, I authorize the school to call either physician below for instructions:

Child's Physician_____Phone_____

Family Physician_____Phone_____

In an emergency, the school has my permission to transport my child for treatment. I authorize emergency treatment enroute to or at the hospital:

Hospital_____

Parent/Guardian Signature_____Date_____

tudent Name_____
Last First Middle
Student Date of Birth____/___/_____

Father's Name_____
Last First
Mother's Name_____
Last First
Guardian _____
Last First
Home address_____Phone_____

Work Phone Mother_____Cell Phone_____
Father_____Cell Phone_____

Medical Alert: Seizure disorder_____ Asthma _____ Other_____
Diabetes _____ Allergies _____
Medications: _____

May health information be shared with staff? Yes_____ No_____
May health information be requested from Physician? Yes_____ No_____

List two neighbors or relatives who will assume temporary care of your child due to illness during school hours if you cannot be contacted:

1 Name_____Phone_____
2 Name_____Phone_____

Incase of accident or serious illness, I request the school to contact me. If unable to reach me, I authorize the school to call either physician below for instructions:
Child's Physician_____Phone_____

Family Physician_____Phone_____

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Hospital_____

Parent/Guardian Signature_____Date_____