

**Saint George Parish School**  
**EMERGENCY & ILLNESS INFORMATION**  
**IMPORTANT: RETURN FIRST WEEK OF SCHOOL**  
**PERSONAL DATA**

GRADE: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Student's Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Father's Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Home E-Mail: \_\_\_\_\_

Mother's Work Place: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother's Cell: \_\_\_\_\_ Work E-Mail: \_\_\_\_\_

Father's Work Place: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father's Cell: \_\_\_\_\_ Work E-Mail: \_\_\_\_\_

**NAME OF LOCAL PERSON TO CONTACT IF PARENT/S ARE NOT AVAILABLE**

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**HEALTH INFORMATION**

**ALLERGIES:** \_\_\_\_\_

Does your child have any health conditions: Yes: \_\_\_\_\_ No: \_\_\_\_\_  
If yes, please indicate:

Is your child on any medications: Yes: \_\_\_\_\_ No: \_\_\_\_\_  
If yes, what kind:

**PHYSICIAN/DENTIST INFORMATION**

Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

**RELEASE**

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE NOTIFY SCHOOL OFFICE IMMEDIATELY OF ANY CHANGES IN THE ABOVE INFORMATION**