



St. Thomas the Apostle Catholic School

Family Emergency Information

Last name of child as it will appear in the directory: _____ First: _____		
Parent/Guardian Contact Emergency Information:		
First Parent/Guardian To Be Called:	Local Phone	
Second Parent/Guardian To Be Called:	Local Phone	
Other Emergency Contacts (if parents/legal guardian cannot be reached):		
Contact #1 Name	Relationship	
Local Phone		
Contact #2 Name	Relationship	
Local Phone		
Contact #3 Name	Relationship	
Local Phone		
Children May Be Picked Up By (in addition to parents and emergency contacts):		
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Children May NOT BE Picked Up By:		<small>(you must provide legal documentation if listing a biological parent)</small>
Name	Relationship	
Name	Relationship	
Comments or Exceptions to Any Information		
Medical Personnel Information		
Family Doctor Name	Family Doctor Phone Number	
Family Dentist Name	Family Dentist Phone Number	
Family Eye Doctor Name	Family Eye Doctor Phone Number	
Preferred Hospital Name	Preferred Hospital Phone Number	
In case of injury or sudden illness, I hereby give authority to the school nurse or school administrator to seek medical attention. I accept responsibility for payment of expenses incurred.		Initial/Date
As a parent/legal guardian, I authorize the treatment of my minor child/ren by a qualified and licensed medical physician in the event of an emergency which, in the opinion of the attending physician, may endanger his or her life, cause physical disability or undue discomfort if delayed.		Initial/Date
Child Lives With _____ What Relation? _____		
Parent or Guardian Signature		Date