2022/2023 ST. ALOYSIUS ACADEMY
EMERGENCY CONTACTS/EMERGENCY DISMISSAL/MEDICAL INFORMATION

Student Name: _____ Grade: _____ Date of Birth: _____
Student lives with ☐ Mother ☐ Father ☐ Both ☐ Guardian Name: _____

Father's Name: _____ Mother's Name: _____
Street Address: _____ Street Address: _____
City, ST Zip: _____ City ST Zip: _____
Home Phone: _____ Home Phone: _____
Place of Employment: _____ Place of Employment: _____
Street Address: _____ Street Address: _____
City, ST Zip: _____ City ST Zip: _____
Work Phone: _____ Work Phone: _____
Cell Phone: _____ Cell Phone: _____
Email: _____ Email: _____

EMERGENCY CONTACTS (when parents cannot be reached)
1st Name: _____ 2nd Name: _____
Home Phone: _____ Home Phone: _____
Work Phone: _____ Work Phone: _____
Cell Phone: _____ Cell Phone: _____

AFTER SCHOOL CARE (other than St. Aloysius Academy)
Organization Name: _____ Caregiver Name: _____
Phone: _____ Home Phone: _____
Cell Phone: _____

EMERGENCY EARLY DISMISSAL (MEANS OF TRANSPORTATION)
In case of an unscheduled emergency early dismissal, my son will take the following means of transportation: ❒ **Car** ❒ **Bus*****

My son is permitted to go home with the following parent/guardian if I cannot come.

1. _____
2. _____
3. _____

Please note important information:

- Extended Day and after-school activities are cancelled.
- **Remember: ***Buses come at varying times. Each district sets its own pick-up time.**
- Students will be sent home by their usual means of transportation unless otherwise indicated.
- The school phone is usually tied up. Please try to avoid having your son make a call.
- **Share your Plan!** Your son should know what to do when he arrives home and you are not there. Where is the key? Whom does he call? Where are the telephone numbers?

- **I realize that my child/children will be using textbooks and other resources from State of Pennsylvania Act 195/90/35 funding.**

OVER →

MEDICAL EMERGENCY

CHILD'S PHYSICIAN: _____ Phone: _____

CHILD'S DENTIST: _____ Phone: _____

I hereby give permission for my child to be given emergency treatment and to be taken to the nearest hospital if necessary Yes ☐ No ☐

AUTHORIZATION FOR EMERGENCY TREATMENT OF MINOR

1. The undersigned is the parent/legal guardian of the minor identified.
2. This authorization is being provided to the Emergency Room for use in the event of the need for emergency treatment of the minor identified when neither the undersigned, the family, physician, nor relative, or friend can be reached to provide consent to treatment.
3. The undersigned hereby authorizes physicians in the Emergency Room to perform on the minor identified, such emergency treatment or procedures as deemed appropriate, provided however, that my consent or the consent of the family physician, friend or relative identified will first be sought, unless the delay, in the opinion of the physician, is imprudent under the circumstances.

Minor's Name: _____

Health/Hospitalization Insurance: _____

Insured/Policy Holder: _____

Policy Number: _____

MEDICAL HISTORY

Please list any medical conditions your son may have: _____

_____

Please list all food and/or drug allergies, including the reaction he experiences: _____

_____

Please list any medications your son is currently taken: _____

_____

May the school nurse administer:

Tylenol	Yes☐	No☐
Antacid Tablets	Yes☐	No☐
Ibuprofen (generic Advil)	Yes☐	No☐
Benadryl (emergency only)	Yes☐	No☐

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