



**SCHOOL:      *EMERGENCY INFORMATION 2021-22***

**\*THIS FORM MUST BE FILLED OUT COMPLETELY**

CHILD'S NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ GRADE \_\_\_\_\_

PARENT'S NAMES \_\_\_\_\_

ADDRESS \_\_\_\_\_ HOME PHONE \_\_\_\_\_

CITY/ZIPCODE \_\_\_\_\_

DAD CELL \_\_\_\_\_ MOM CELL \_\_\_\_\_

DAD EMAIL \_\_\_\_\_ MOM EMAIL \_\_\_\_\_

DAD WORK# \_\_\_\_\_ MOM WORK# \_\_\_\_\_

AUTHORIZED PICK-UP \_\_\_\_\_

AUTHORIZED PICK-UP \_\_\_\_\_

EMERGENCY CONTACT: 1. \_\_\_\_\_ CELL \_\_\_\_\_

**(Other than parents)**

2. \_\_\_\_\_ CELL \_\_\_\_\_

3. \_\_\_\_\_ CELL \_\_\_\_\_

**CONSENT FOR EMERGENCY MEDICAL TREATMENT**

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO REFORMATION LUTHERAN SCHOOL, TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A LICENSED PHYSICIAN (M.D.), OSTEOPATH (D.O) OR DENTIST (D.D.S.) FOR

\_\_\_\_\_  
**(Child's Name)**

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

\*\*\*CHILD HAS THE FOLLOWING MEDICATIONS/ALLERGIES: \*\*\* **(IF none, please write "NONE")**

\_\_\_\_\_

**Signature of Parent or Authorized Representative      Date**