SCHOOL CITY OF HOBART EMERGENCY FORM SCHOOL YEAR 2013 TO 2014

NAME _____
LAST FIRST MIDDLE

BIRTHDATE _____ M_____ F_____ GRADE _____

STUDENT'S HOME ADDRESS _____ CITY _____ Bus # _____

PHONE _____ EMAIL _____ CHECK IF NEW ADDRESS THIS SCHOOL YEAR _____
IF STUDENT WORKS LIST LOCATION _____ PHONE _____
PRIMARY LANGUAGE SPOKEN AT HOME _____

PLEASE CHECK BOX/BOXES BELOW TO INDICATE WHO HAS LEGAL CUSTODY
(UNLESS OTHERWISE NOTIFIED, THE SCHOOL WILL RELEASE STUDENT TO THOSE LISTED BELOW)

☐ FATHER'S NAME _____ ADDRESS _____ PHONE _____

☐ MOTHER'S NAME _____ ADDRESS _____ PHONE _____

☐ GUARDIAN'S NAME _____ ADDRESS _____ PHONE _____

FATHER'S WORKPLACE _____ PHONE _____ CELL/PAGER _____

MOTHER'S WORKPLACE _____ PHONE _____ CELL/PAGER _____

GUARDIAN'S WORKPLACE _____ PHONE _____ CELL/PAGER _____

BROTHERs & SISTERS (INCLUDE STEP-SIBLINGS) AGE SCHOOL ATTENDING

_____

_____

_____

_____

EMERGENCY CONTACTS WHEN PARENTS ARE NOT AVAILABLE, WHOM SHOULD WE CONTACT LOCALLY?

1ST CONTACT _____
NAME HOME PHONE CELL WORK

2ND CONTACT _____
NAME HOME PHONE CELL WORK

MY CHILD IS ALLERGIC TO THE FOLLOWING: _____
IF A REACTION SHOULD OCCUR, WHAT SHOULD BE DONE? _____
INDICATE ANY PERTINENT HEALTH PROBLEMS OR CONDITIONS: (LIST ROUTINE MEDICATIONS, GLASSES, CONTACT LENS, ETC.)

_____

_____

IF A DOCTOR'S/DENTIST'S CARE SEEMS NECESSARY, CAN WE CALL YOUR DOCTOR/DENTIST? YES _____ NO_____
NAME OF FAMILY DOCTOR _____ PHONE _____
NAME OF FAMILY DENTIST _____ PHONE _____

IN CASE OF SERIOUS ILLNESS OR INJURY, I GIVE MY PERMISSION FOR THE ABOVE NAMED STUDENT TO BE TREATED AT ST. MARY MEDICAL CENTER EMERGENCY ROOM OR A LOCAL EMERGENCY ROOM. IF OUT OF TOWN, TREATMENT MAY BE GIVEN AT A LOCAL EMERGENCY ROOM

SIGNED _____
PARENT OR GUARDIAN DATE

(Information on this form may be shared with the appropriate personnel for health and emergency purposes)