SAINT JOHN VIANNEY CATHOLIC SCHOOL

EMERGENCY PROCEDURE FORM

PLEASE PRINT CLEARLY

Student Last Name	First	Middle Initial
Date of Birth	Sex	Religion
Mother/Guardian Name	Home Address	Zip
Business Name	Business Address	Zip
Home Phone	Business Phone	Cell
Father/Guardian Name	Home Address	Zip
Business Name	Business Address	Zip
Home Phone	Business Phone	Cell

If the school cannot contact a parent/guardian, name a friend or relative who may be called upon if the child is ill. You may also name a doctor the school may call.

Friend or Relative	Address	Zip
Home Phone	Business Phone	Cell
Friend or Relative	Address	Zip
Home Phone	Business Phone	Cell
Family Doctor's Name	Office Pone	

OVER

PLEASE PRINT CLEARLY

Insurance Provider | Group Number | ID Number

Preferred Hospital

Allergies/Special Conditions:

Please indicate any EMERGENCY MEDICAL information that we should know below:

I authorize St. John Vianney Catholic School to seek Emergency Medical care for my child (i.e. call an ambulance).

_____Yes _____No

I understand that it is my responsibility to keep the information on this form current.

Parent/Guardian Signature: _____ Date: _____