



# SAINT JOHN VIANNEY CATHOLIC SCHOOL

## EMERGENCY PROCEDURE FORM

**PLEASE PRINT CLEARLY**

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

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

PLEASE PRINT CLEARLY

Insurance Provider \_\_\_\_\_ Group Number \_\_\_\_\_ ID Number \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

Allergies/Special Conditions: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I give St. John Vianney Catholic School permission to administer the following medications to my child:**

\_\_\_\_\_ Tylenol \_\_\_\_\_ Advil/Motrin \_\_\_\_\_ Benadryl \_\_\_\_\_ Tums

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

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

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**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_