

Saint Patrick Religious Education Program
Emergency Evacuation Information

Date _____ *only the persons listed below will be allowed to pick up your child in an emergency situation.*

Child's Name _____

Age _____ Date of Birth _____

Address _____

Mother's Name _____

Address _____

Home Phone _____ Cell Phone _____

Work Address _____

Work Phone _____ Other # _____

Father's Name _____

Address _____

Home Phone _____ Cell Phone _____

Work Address _____

Work Phone _____ Other # _____

Emergency Contact #1

Name _____

Address _____

Home Phone _____ Cell Phone _____

Work Address _____

OVER

Work Phone _____ Other # _____

Emergency Contact #2

Name _____

Address _____

Home Phone _____ Cell Phone _____

Work Address _____

Work Phone _____ Other # _____

Medical Information Dr. Name _____ Phone _____

Existing medical conditions _____

Allergies (be specific) _____

Medications child is taking _____

Medication Allergies _____

Insurance Information

Company Name _____ Group # _____

Identification # _____ Last Tetanus Shot _____

I state that we are the parents/ guardians having legal custody of the above child and attest that the information above is correct. I authorize the above Church Program Staff to obtain emergency treatment for my child. I consent to an E-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care to be rendered to the minor at a recognized medical facility, under the general or special supervision of a licensed physician or surgeon.

This staff will not be responsible for complications that may occur as a result of false information given.

PARENT' S SIGNATURE _____

DATE _____

WITNESS SIGNATURE _____

DATE _____