ST. RAPHAEL CATHOLIC SCHOOL
STUDENT EMERGENCY INFORMATION
Please fill out one form for each student.

STUDENT NAME: _____ CLASS: _____
LAST FIRST

Mother's Name: _____ Father's Name: _____

Mother's daytime phone: _____ _____ _____
Cellular Other

Father's daytime phone: _____ _____ _____
Cellular Other

List neighbors, friends, or relatives who will assume temporary care of your child if you cannot be reached. List in order to be contacted:

1. **NAME: _____ PHONE: _____**

ADDRESS: _____ RELATIONSHIP: _____

2. **NAME: _____ PHONE: _____**

ADDRESS: _____ RELATIONSHIP: _____

3. **NAME: _____ PHONE: _____**

ADDRESS: _____ RELATIONSHIP: _____

In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated below and to follow his instructions. If it is not possible to contact this physician, the school may make whatever arrangements seem necessary.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**

_____ I have completed the reverse side of this form with the Student's Health History.
(Initial)

PHYSICIAN'S NAME: _____ OFFICE PHONE: _____

OFFICE ADDRESS: _____ EMERGENCY # _____

INSURANCE INFORMATION: _____

PLEASE COMPLETE THE BACK OF THIS FORM.

Student Health History

Please circle "yes" or "no", or answer the question as appropriate.

DOES YOUR CHILD HAVE…?

Allergies **Yes** **No**

If yes, what is your child allergic to? _____
Is medication needed at school? _____

Asthma **Yes** **No**

If yes, when was the last attack?_____
Is medication needed at school? _____

Diabetes **Yes** **No**

Does your child need insulin? _____

Seizures **Yes** **No**

If yes, when was the last seizure? _____
Is your child on medication for seizures? _____
Is medication needed at school? _____

Vision Problems? **Yes** **No**

Does your child wear glasses or contacts? _____

Hearing Problems? **Yes** **No**

Does your child have a known hearing loss? **Yes** **No**
Does your child wear a hearing aid? **Yes** **No**

Heart Problems? **Yes** **No**

If yes, name of problem? _____
Is exercise limited? **Yes** **No**
Is child on medication for this problem? **Yes** **No**

Orthopedic Problems? Yes **No**

If yes, name of problem: _____

Other health problems? Yes **No**

If yes, please describe: _____

Was your child hospitalized or did your child have major health changes within the last year? **Yes** **No**

_____