Monsignor Donovan
CATHOLIC HIGH SCHOOL

Student Emergency Information

Student's Name: ____ Date of Birth: __________
Last First Middle

Student's Mailing Address: ________________________________Home Phone: __________

________________________________Cell Phone: ____________

Student's Grade:_____________ Gender: _____________ SS# _________________

Mother's Name:____

Place of Employment: ____

Cell Phone: __________________________ Work Phone: _____________________

Father's Name: ____

Place of Employment: ____

Cell Phone: ____________________________ Work Phone: _____________________

Step Mother's Name:____

Place of Employment: ____

Cell Phone: ___________________________ Work Phone: _____________________

Step Father's Name: ____

Place of Employment: ____

Cell Phone: ____________________________ Work Phone: _____________________

Are there any individuals who your child is not allowed have contact with? Please list these individuals.

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List two individuals who will assume temporary care of your child in case of emergency:

Name: _____________________________ Name:____________________________

Address: ___________________________ Address: __________________________

Home Phone: _________ Work: _________ Home Phone: _________ Work: _________

Cell Phone or Pager: ____________________ Cell Phone or Pager: ___________________

Important Note: Please notify the school immediately concerning changes to information on this form.

INSURANCE INFORMATION

In case of accident or serious illness, I request the school to contact me. If the school is unable to contact me, I hereby authorize the school to call the physician indicated below and to follow his or her instructions. If it is not possible to contact the physician, the school may make whatever arrangements seem necessary. ***The Archdiocese of Atlanta (policy #5460) requires that all students have accident insurance coverage.***

Do you have accident insurance on this child? ☐ YES ☐ NO

Name of Insurance Company: ___________________________________ Policy# __________________

Parent/Guardian Signature: ___________________________________ Date Signed: _____________

Does this student have any major or unusual heath concerns? ☐ YES ☐ NO

Remarks: ____

Allergies: __________________________________Other Conditions: ___________________________

Physician: _________________________________ Dentist: ____________________________________

Hospital Preference: ____

AUTHORIZATION FOR MEDICATION

The front office keeps a supply of over-the-counter medications for headaches, painful braces or any simple ailments, etc. These will only be dispensed if there is a signed parent authorization. A record of all medications dispensed to students will be maintained in the front office. I give my student permission to receive the following **checked** (☑) over –the-counter medications:

- ☐ Acetaminophen (Tylenol)
- ☐ Ibuprofen (Advil, Motrin)
- ☐ Antacid Tablets (Tums)
- ☐ Antibiotic Ointment (Neosporin)
- ☐ Diphenhydramine (Benadryl)
- ☐ Pseudoephedrine (Sudafed)
- ☐ Cough Drops
- ☐ Eye Drops (Visine Tears)

***Important* -** Please list <u>any</u> drug allergies **below:**

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Parent Signature ___________________________________ Date_______________

PRESCRIPTION MEDICATION CONSENT

Name of Medication _________________________ Date ______________________________________

Times to be given ___________________________ Physician's Name ___________________________

Dosage _____________________________________ Physician's Phone ___________________________

The physician must be notified immediately if the following conditions or circumstances arise in connection with the administration of this medication.

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I authorize the school to administer the above medication and release Monsignor Donovan Catholic High School and its employees from any liability in administering the above medication according to the stated dosage and times.

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Parent Signature Date