# HOLY ANGELS CATHOLIC ELEMENTARY SCHOOL

230 North 8th Avenue • West Bend, WI 53095
(262) 338-1148 www.has.pvt.k12.wi.us

## EMERGENCY INFORMATION FORM

**Family Name:** _____

Address: _____ Home Phone: _(____)_____

Student(s): _____ Grade: _____ Date Of Birth: _____

_____ _____ _____

_____ _____ _____

Father's Name: _____ Daytime Phone: _(____)_____

Daytime Place of Work: _____ Address:_____

Mother's Name: _____ Daytime Phone: _(____)_____

Daytime Place of Work: _____ Address: _____

Legal Guardian(s): _____

If this is a "blended family" (remarriage, etc.), please briefly explain:_____

_____

Emergency / Health / Illness:

First person to contact: _____ Daytime Phone: _(____)_____

Cell Phone: _(____)_____

Person to contact if
parent is unavailable: _____ Daytime Phone: _(____)_____

Cell Phone: _(____)_____

If emergency treatment is required and the parent cannot be reached immediately, may the school authorities use their own judgement in calling the doctor indicated below or move student to the hospital? Yes: ____ No: ____

If "No", what do parents want done? _____

A "Yes" response does not absolve the parent from primary responsibility for all medical expenses.

Personal Physician: _____ Phone: _(____)_____

Personal Dentist: _____ Phone: _(____)_____

If any of the above mentioned students is taking medication, has special medical or physical problem, has allergies, or is required to have special seating because of sight or hearing, please explain:

Student:_____ Needs: _____

_____.

Student:_____ Needs: _____

_____.

See reverse side for Emergency School Closing Information

I attest that the above information and statements are complete and accurate to the best of my knowledge and belief.

Father's Signature: _____ Date: _____

Mother's Signature: _____ Date: _____