

**ST. AGNES SCHOOL  
EMERGENCY INFORMATION CARD**

**Important: RETURN FIRST WEEK OF SCHOOL**

(Please print)

Student's Name \_\_\_\_\_ Soc Sec # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Grade \_\_\_\_\_ (Last) \_\_\_\_\_ (First) \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ HomePhone (\_\_\_\_) \_\_\_\_\_  
Street City St Zip

Parents \_\_\_\_\_  
Mother (Guardian) Father (Guardian)

Place of Work \_\_\_\_\_  
Mother Office Phone

Place of Work \_\_\_\_\_  
Father Office Phone

Name of Local Persons to contact if Parent/Guardian is not available (this must be completed).

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

**RELEASE**

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 or, if not available, the Principal may make whatever arrangements seem necessary.

Mother/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Father/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

If it becomes necessary to send your child to a doctor or hospital, will you assume responsibility for paying the bills? Yes \_\_\_ No \_\_\_ Does the family have hospitalization insurance? Yes \_\_\_ No \_\_\_ Does your child have the accident insurance policy issued through the school? Yes \_\_\_ No \_\_\_  
Date of last Tetanus Vaccination: \_\_\_\_/\_\_\_\_/\_\_\_\_

Does your child have any unusual health conditions? \_\_\_\_\_

Physician Name \_\_\_\_\_ Office Phone \_\_\_\_\_

Address \_\_\_\_\_

Dentist Name \_\_\_\_\_ Office Phone \_\_\_\_\_

Address \_\_\_\_\_

**SPECIAL NOTE:** Please notify school officials immediately as to changes to any information stated.