



ST. PETER CATHOLIC SCHOOL
STUDENT EMERGENCY INFORMATION

Child's Name _____ Male Female Birth date _____
Home Address _____
Phone _____ Cell _____

Father/Guardian's Name _____ Occupation _____
Name & Address of Employer _____
_____ Phone _____ Cell Phone _____
Mother/Guardian's Name _____ Occupation _____
Name & Address of Employer _____
_____ Phone _____ Cell Phone _____

If neither parent nor guardian can be reached in case of emergency, call the following to assist with information or to pick up my child:

Name _____ Telephone _____ Cell _____
Address _____ Relationship to Child _____
Name _____ Telephone _____ Cell _____
Address _____ Relationship to Child _____
Name _____ Telephone _____ Cell _____
Address _____ Relationship to Child _____

Use back of form if needed.

Persons NOT permitted to remove child from school _____

Is there a personal restraining order in force against the above listed person or persons? _____

Child's Physician: _____

Name	Address	Phone
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Child's Dentist: _____

Name	Address	Phone
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Hospital Preference: _____

Name	Address	Phone
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I hereby authorize representatives of St. Peter Catholic School to take my child to the above named physician or facility for medical treatment in the event of an emergency in which neither parent can be reached. If the above named physician cannot respond, I authorize any licensed physician or medical center to treat my child. I realize that I am responsible for any expenses incurred during treatment. I further authorize the hospital or emergency care facility to release my child to the school representative should care no longer be required.

Signature _____ Date _____