ACADEMY OF THE HOLY FAMILY

54 West Main Street * Baltic, Connecticut 06330 * Telephone: (860)822-9272 * Fax: (860) 822-1318
School Nurse: Cheryl Johnson, LPN - - E-mail: schoolnurse@ahfbaltic.org

Emergency Contact Information/Consent Form **Year: 20____ to 20____**

Student Information

Student's Full Name: ____________________ Date of Birth: __________ Grade: _____

Home Address: ____

Street Number City/State/Zip Country

Home Phone: ____________ Cell Phone: ____________ Student Email Address: ____________

Allergies ____________________ **Medications** ____________________

Parent/Guardian Information—First Contact

Name: ____________________________ Relationship: ______________

Address (if different from above): ____________________________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

E-mail: ____________________

Emergency Contact #1 (In case parents/guardians cannot be reached and are authorized to pick up your child)

Name: ____________________________ Relationship: ______________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

Emergency Contact #2 (In case parents/guardians cannot be reached and are authorized to pick up your child)

Name: ____________________________ Relationship: ______________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

INTERNATIONAL STUDENTS – **Please provide the contact information of an English-speaking individual residing in the United States**

Name: ____________________________ Relationship: ______________

Home Address: ____

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________

AUTHORIZATION FOR MEDICAL TREATMENT

In the event of an illness or accident, I hereby authorize Academy of the Holy Family High School. To act on my behalf for the student named above in the securing of medical, surgical, psychological and/or dental treatment. In the event of an emergency, I hereby give my permission to the health care provider selected by Academy of the Holy Family High School to hospitalize, secure proper treatment for , and to order injection, anesthesia, or surgery for the student named above. If **such an event occurs, I understand that every effort will be made to contact me as soon as possible.** I certify that I am the parent/guardian or have the legal ability to sign these authorizations on behalf of the student named above. I understand I am responsible for all expenses that the above named student insurance does not pay.

➔ **Parent/Guardian Initial Here:** ______ **➔Date:** __________

HIPPA:

I give the Academy of the Holy Family Heal Office permission to obtain/provide/exchange information with any health care provider of health care facility. This included but is not limited to hospitals, walk-in center, emergency care centers and individual physicians that my daughter may be sent to for medical or psychological evaluation and treatment. This exchange of information includes staff responsible for the health and well-being of student. I understand that I may withdraw my consent at anytime by providing a written request limiting the exchange of information. The Family Right to Privacy Act will protect information placed i my daughter's school health record.

➔ **Print Parent/Guardian Name:** ____________________ **Relationship:** ____________

➔ **Signature Parent/Guardian:** ____________________ **➔Date:** ____________