Academy of the Holy Family
54 West Main Street Baltic, CT 06330 ● Phone: (860) 822-9272 ● FAX: (860) 822-1318
E-Mail: schoolnurse@ahfbaltic.org

EMERGENCY CONTACT & PERMISSION for MEDICAL TREATMENT

ALL INFORMATION MUST BE IN ENGLISH.

Student Last Name **First** **Middle** **Student Nickname**

____

Grade: ______ **Birth Date** ____ /____ /____ **Birthplace** ________________________ **Age** ______
Month/day/year

Mailing Address Street or PO Box Number ☐ **Mother** ☐ **Father** ☐ **Both** **Student Phone #:**_______________

____

Main Physical Street Address ☐ **Mother** ☐ **Father** ☐ **Both** **City, State, Zip Code** **Country**

____

Secondary Physical Street Address ☐**Mother** ☐**Father** **City, State, Zip Code** **Country**

____

Student's Primary Language: ___________________

Language Spoken at Home: _______________________ ☐ **Interpreter needed to communicate w/family?**

Student lives with: ☐ **Both Parents** ☐ **Mother** ☐ **Father** ☐ **Shared Custody**

☐ **Father/Stepmother** ☐**Mother/Stepfather** ☐**Guardian**

Guardian is: ☐**Grandparent** ☐**Aunt/Uncle** ☐**Sibling** ☐**Foster Parent** ☐**Other**_______________

☐ **Sole Custody: If one parent has sole and restrictive custody of a student, valid court papers must be provided to the school.**

The registering parent is considered the primary residential custodian.

The secondary custodian would like/is allowed to receive communications from the school ☐**Yes** ☐**No**

Mother/Stepmother: ________________________________

Unlisted ☐ **Home Phone # (**______**)** ________________________ **Cell (**______**)** __________________________

E-mail: _________________________ **Employer** ________________________ **Work# (**____**)** _________________

Father/Stepfather: ________________________________

Employer __________________________________ **Work# (**_____**)** _________________________

Unlisted ☐ **Home Phone # (**______**)** ________________________ **Cell (**_____**)** __________________________

E-mail: _________________________ **Employer** ________________________ **Work# (**_____**)** _________________

Guardian: ___________________________ **Cell (**_____**)** ___________________**Home (**___**)** ______________

Employer________________________________ **Work# (**_____**)** ______________________________

E-mail:_____________________________________

If your daughter is a day student and absent please call the school office ASAP; if we do not hear from you, we will call the following phone numbers (please fill in) to verify absence:
Phone #1 (_____**)** ___________________ **Phone#2 (**____**)** _________________________

Parent/Guardian **Signature 1** **Signature 2 (Optional)** **Date**

Student's Name: ______________________________________ **Date of Birth:** ____________________

<u>EMERGENCY CONTACTS</u> – ***In the event your daughter is <u>ill or injured</u> OR if an emergency school closure prevents it's operation, students will be released ONLY to their parents or emergency contacts. List those who may pick up or be contacted about your daughter on this page.***

Name	Relationship	Phone (include area code) Address
______________________	____________	(_____)____
______________________	____________	(_____)____
______________________	____________	(_____)____
Out of State:		
______________________	____________	(_____)____

I agree to pick up my sick or injured daughter in a timely manner when contacted for need to do so.

List others that *cannot* pick up your daughter at school or in an emergency evacuation – attach additional page if needed:

____

____

Insurance Information – Insurance Card or Copy of Insurance (front & back) must be given to the Nurse's office.

Name of Insurance Carrier: _______________________ Group No.: _______________ Policy No.: ______________

Insurance Phone: _________________________________ RX Phone: ______________________________________

Insurer Name: ________________________ Date of Birth ____/____/____

Hospital to transport student to _____________________ Dr. Name / Phone No ________________________________

Please check with your Insurance Carrier to see if your daughter will be covered while she attends AHF.

I grant permission for the Academy of the Holy Family to administer routine medical treatment for my daughter for minor illnesses/injuries. I also authorize the Academy to take my daughter to either the school physician or medical clinic for acute medical reasons. If your insurance policy requires a referral from your daughter's primary care physician prior to treatment, please have your physician write a referral letter to AHF in order for our school physician to treat your daughter when necessary. Please attach the referral letter to the Parental Authorization Form.

Every attempt will be made however, if circumstance make it impossible for the school to reach me, the school has my permission to take (or call 911 if necessary) my daughter to the emergency room at the nearest hospital or walk-in clinic. I hereby authorize the medical staff to provide necessary treatment (medical/psychological/dental), should a physician deem necessary for the well-being of my daughter. I authorize qualified emergency medical professionals to examine and in the event of injury or serious illness, administer emergency care to the above named student. I understand every effort will be made to contact me to explain the nature of the problem prior to any involved treatment. In the event it becomes necessary for the school district staff-in-charge to obtain emergency care for my daughter, neither s/he nor the district assumes financial liability for expenses incurred because of the accident, injury, illness and/or unforeseen circumstances.

I agree to notify the Academy within 24 hours if my daughter or any member of my immediate household has developed a communicable disease. I agree to notify the Academy immediately if the disease is life threatening.

If I live within a 100 mile radius of the Academy I agree to take the responsibility for the following:

- **To meet my daughter at the Emergency Room should she be taken there by ambulance or by staff members?**
- **To take my daughter to the Emergency Room myself if not life threatening.**
- **To be responsible for transportation to regularly scheduled doctor's appointments for acute illnesses, and/or to be responsible for transportation to specialist's appointments**.
- **In addition if I live within the 100 mile radius or outside the radius of 100 miles and in the states of NY, NJ, MA, RI, or CT, I will as soon as possible arrive at the hospital or at AHF to take my daughter home for a 24 hours for observation or as required if emotional circumstances before bring her back to school. This is to insure that your daughter has no complication from the accident or illness.**

I state that all information is true and accurate. I understand this information may be shared with staff who are supervising the student, and/or who need the information in order to protect the health and safety of the student and provide a safe learning environment.
If any information changes during the school year, inform the school as soon as possible. Attach additional pages if needed.

Parent/Guardian	______________________________ Signature 1	______________________________ Signature 2 (Optional)	________________ Date