EMERGENCY CONTACT INFORMATION 2026-2027

Student's Name _____
Last First M.I. Date of Birth Sex: M/F Grade

Student's Name _____
Last First M.I. Date of Birth Sex: M/F Grade

Student's Name _____
Last First M.I. Date of Birth Sex: M/F Grade

Father/Guardian's Name _____ Social Security Number _____ - ____ - _____

Place of Employment _____ Occupation _____

Business Phone _____ Cell Phone _____ Okay to Call? Yes / No

Email Address: _____

Mother/Guardian's Name _____ Social Security Number _____ - ____ - _____

Place of Employment _____ Occupation _____

Business Phone _____ Cell Phone _____ Okay to Call? Yes / No

Email Address: _____

Marital Status of Parents: _____ Single _____Married _____ Divorced _____Widowed

Name of Custodial Parent or Guardian (if applicable) _____

Home Address (Primary Mailing Address)

Street Address _____ City _____ ZIP Code _____

Date of Admission: _____

Names of persons to be notified in an emergency when parent is not available. Also, indicate if they may pick up child(ren) after school. Please list relationship to child.

1. Name: _____ Relationship: _____ Phone _____

   Check one or both: Emergency Contact _____ Pick-up _____

2. Name: _____ Relationship: _____ Phone _____

   Check one or both: Emergency Contact _____ Pick-up _____

3. Name: _____ Relationship: _____ Phone _____

   Check one or both: Emergency Contact _____ Pick-up _____

4. Name: _____ Relationship: _____ Phone _____

   Check one or both: Emergency Contact _____ Pick-up _____

Name(s) of person(s) to whom child(ren) **MAY NOT** be released (per Court Order on file):

_____

Medical Information

Physician's Name _____ Phone _____

Preferred Hospital _____

Insurance Carrier _____ Group # _____ Contract # _____

Current Continuing Medication(s)

Child's Name_____ _____

Child's Name_____ _____

Any OTC or prescription medications to be administered at school must be accompanied by a form signed by the physician and a parent/guardian.

Last Tetanus Shot

Child's Name _____ Date _____ Child's Name _____ Date _____

Child's Name _____ Date _____ Child's Name _____ Date _____

Any allergies or other health information the school should know

Child's Name_____

_____

Child's Name_____

_____

I herby give my permission to St. Paul Lutheran School to secure emergency medical and/or emergency surgical treatment for the child(ren) named on this form while in the school's care.

_____ _____

Signature of Parent or Guardian Date