CCHRS
CORPUS CHRISTI ✝ HOLY ROSARY SCHOOL
A TRADITION OF SUCCESS!

Emergency Authorization Form 2017-2018

ANY CHANGES PLEASE NOTIFY THE SCHOOL OFFICE IMMEDIATELY – PLEASE ANSWER ALL QUESTIONS

One Per Child

Grade_____ Student's Date of Birth _____ Social Security#_____

Student's Name _____
(Please Print) Last Name First Name Middle Name

Home Address _____Home Phone_____ _____

Father's Name _____
(last name) (first name)

Business Phone: (_____)_____ Cell Phone (_____)_____

Business Address: _____

E-mail Address: _____

Mother's Name _____
(last name) (first name)

Business Phone: (_____)_____ Cell Phone (_____)_____

Business Address: _____

E-mail Address: _____

MEDICAL ALERT: Seizure disorder_____ Asthma_____ Diabetes____ Other _____

Allergies (**SPECIFY**) _____ NONE_____

MEDICATION(S): _____

May health information be shared with staff? Yes_____ No_____

List two neighbors or relatives who will assume temporary care of your child due to illness during school hours if you cannot be contacted:

1. **Name**_____ **Phone** _____

Relationship to student_____ **cell#**_____

2. **Name**_____ **Phone** _____

Relationship to student_____ **cell#**_____

In case of accident or serious illness, I request the school to contact me. If unable to reach me, I authorize the school to call physician below for instructions:

Child's Physician_____Phone_____

In an emergency, the school has my permission to transport my child for treatment. I authorize emergency treatment enroute to or at the hospital:

Hospital_____

Parent's Signature_____Date_____

(REVISED 6/17)