

**Saint Joseph School**  
100 Spring Street  
Fairhaven, MA 02719  
**508-996-1983**

**Family and Emergency Information – 2012-2013 (updated annually)**

Student Name \_\_\_\_\_ Grade \_\_\_\_\_  
(Last) (First) (MI)

Address \_\_\_\_\_  
(No.) (Street) (City/Town) (Zip)

Date of Birth \_\_\_\_\_ Male \_\_\_\_ Female \_\_\_\_ Social Security Number (optional) \_\_\_\_\_

Phone \_\_\_\_\_ **Email** \_\_\_\_\_ Primary Contact # \_\_\_\_\_

Religion \_\_\_\_\_ Parish \_\_\_\_\_

City/Town of Parish \_\_\_\_\_

Student lives with \_\_\_\_\_ Guardian \_\_\_\_\_ (if applicable)

Race (optional – used to provide information for yearly statistical reports) \_\_\_\_\_

Father's Name \_\_\_\_\_  
(First) (Last)

Mother's Name \_\_\_\_\_  
(First) (Last)

Religion \_\_\_\_\_

Religion \_\_\_\_\_

Parish \_\_\_\_\_

Parish \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

Father's Occupation \_\_\_\_\_

Mother's Occupation \_\_\_\_\_

Title or Position \_\_\_\_\_

Title or Position \_\_\_\_\_

Name of Company \_\_\_\_\_

Name of Company \_\_\_\_\_

Business Address \_\_\_\_\_

Business Address \_\_\_\_\_

Business Phone \_\_\_\_\_

Business Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_

E-Mail \_\_\_\_\_

E-Mail \_\_\_\_\_

**Other siblings presently attending Saint Joseph School**

1. \_\_\_\_\_ Grade \_\_\_\_\_ 2. \_\_\_\_\_ Grade \_\_\_\_\_

**List two available neighbors/relatives who could assume temporary care of your son/daughter should you be unavailable.**

Name \_\_\_\_\_ Relation \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relation \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**(Over)**

Are there any individuals who are restricted from picking up your son/daughter? \_\_\_\_\_

Name of individual \_\_\_\_\_ Relationship to child \_\_\_\_\_

Official Parent Signature \_\_\_\_\_

### Health Information

Health Update for \_\_\_\_\_ Grade \_\_\_\_\_

Please fill in the following information, which is important in the case of serious illness or emergency.  
Please notify the school nurse of any changes in student health history or changes in medication.

Health Insurance Company \_\_\_\_\_ Policy Number \_\_\_\_\_

If allergies exist, please describe the specific allergic reaction:

Allergies to environment \_\_\_\_\_

Allergies to food \_\_\_\_\_

Allergies to medication \_\_\_\_\_

Vision problems \_\_\_\_\_ Glasses \_\_\_\_\_ Contacts \_\_\_\_\_

Hearing problems \_\_\_\_\_

Illness, injuries, or surgery since last year? \_\_\_\_\_ If yes, please describe.

List medications taken on a regular basis, dosage, and time taken and reason that the medication is taken.

| Medication | Dose | Time Taken | Reason for taking medication |
|------------|------|------------|------------------------------|
|------------|------|------------|------------------------------|

**Please refer to medication administration policy in the student handbook. Medication forms are needed for any medication given to students at school.**

Is there any additional information that the school nurse should be aware of? Please explain.

In case of accident or serious illness, and I am unable to be contacted, the school will call the physician named below and follow his instructions. If it is impossible to contact the physician, the school will make whatever arrangements are deemed necessary.

Name of Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

I give permission for the school nurse to share pertinent medical information with the school staff.

Parent/Guardian Signature \_\_\_\_\_

Date \_\_\_\_\_