Today's Date:_____

EMERGENCY CONTACT/RELEASE AND CONSENT FORM

Please complete both sides of this form with a black or blue ink pen. Do not use pencil.

STUDENT INFORMATION

_____ _____ ____/____/_____ _____

Student's Last Name | Student's First Name | Date of Birth | Class Year

_____ _____-_____-_____ (_____)_____ (_____)_____

Grade in Fall 2013 | Social Security Number | Home Phone | Student Cell Phone

_____ *Is this a new address*?

Student's Address | City | St | Zip ❑Yes ❑No

Parents Email Address 1._____ 2._____

Student Lives with: ❑Mother ❑Father ❑Both Parents ❑Joint Custody ❑Guardian

In case of a major emergency, I (WE), the undersigned Parent/Guardian of _____ hereby authorize the Archbishop Riordan Faculty/Staff as agents for the undersigned to:

- ❑ Release my son. He may leave campus to go home on his own.
- ❑ DO NOT release my son until an authorized person picks him up from school (see below).

If I (WE) cannot be contacted, we designate the following individuals as emergency contacts:

_____ (_____)_____

Name | Relationship to Student | Phone Number

_____ (_____)_____

Name | Relationship to Student | Phone Number

_____ (_____)_____

Name | Relationship to Student | Phone Number

PARENT INFORMATION

_____(_____)_____(_____)_____(____)_____

Father/Guardian (Print) Signature | Cell Phone | Work Phone | Home Phone

_____

Father's Address (if different from student)

_____(_____)_____(_____)_____(____)_____

Mother/Guardian (Print) Signature | Cell Phone | Work Phone | Home Phone

_____

Mother's Address (if different from student)

-OVER-

STUDENT MEDICAL INFORMATION

PRIMARY PHYSICIAN

_____ (_____)_____
Name Phone Number

_____
Address City St Zip

EMERGENCY PHYSICIAN

_____ (_____)_____
Name Phone Number

_____
Address City St Zip

MEDICAL CONDITIONS (please list any medical conditions that your son has, e.g., diabetes, epilepsy, heart condition, etc.)

_____

_____

_____

_____

DISABILITIES_____

ALLERGIES (e.g., hay fever, strawberries, peanuts, shell fish, etc.)

_____

_____

_____

❑ My son has no known allergies.

ALLERGIES TO MEDICATIONS

_____

_____

_____

❑ My son has no known allergies to medication.

MEDICATIONS TO BE SELF-ADMINISTERED BY THE CHILD:

_____ _____ _____
Name of Medication Dosage Frequency

_____ _____ _____
Name of Medication Dosage Frequency

In case of accident, may we contact your family doctor? ❑Yes ❑No

May the school provide your son non-aspirin pain reliever as needed? ❑Yes ❑No