

Ascension

After School

Emergency Information Sheet

Child's Name: _____ Age/Grade: _____ Sex: _____

Address: _____ Zip _____

Home Phone: _____ Birth date: _____

Parent/Guardian Name: _____ Home Phone : _____

Home Address: _____
(street address) (city) (state) (zip code)

Place of Employment: _____ Work Phone: _____

E-mail address: _____ Cell Phone: _____

Parent/Guardian Name: _____ Home Phone: _____

Home Address: _____
(street address) (city) (state) (zip code)

Place of Employment: _____ Work Phone: _____

E-mail Address: _____ Cell Phone: _____

Child's Physician: _____ Office Phone: _____

Preferred Hospital: _____

Allergies (food or drug): _____

Special Medical Concerns: _____

These individuals have permission to make medical decisions on your behalf and are authorized to pick up if the above named child becomes ill or injured at school and parents cannot be reached:

Name: _____ Daytime Phone: _____

Name: _____ Daytime Phone: _____

Additional people authorized to pick up your child:

Name: _____ Daytime Phone: _____

Name: _____ Daytime Phone: _____

In case of a medical need involving my child, I request the staff of Ascension to contact us at the numbers provided. In the event that we cannot be reached, I authorized the Ascension staff to obtain emergency medical care for my child.

Parent/Guardian Signature: _____ Date: _____