

**DIOCESE OF CHARLOTTE - MACS**  
**STUDENT EMERGENCY INFORMATION**  
 School Year 20\_\_ - 20\_\_

_____ <b>SCHOOL GRADE</b> _____		LAST NAME	FIRST NAME
		HOME PHONE	PARISH <input type="checkbox"/> Non-Catholic
			DOB
ADDRESS	CITY	STATE	ZIP
MOTHER/GUARDIAN NAME	HOME PHONE	BUSINESS PHONE	MOBILE/PAGER
FATHER/GUARDIAN NAME	HOME PHONE	BUSINESS PHONE	MOBILE/PAGER
IN CASE OF EMERGENCY, CONTACT:			
1. _____			
NAME	ADDRESS	PHONE	
2. _____			
NAME	ADDRESS	PHONE	
STUDENT'S PHYSICIAN	PHONE	STUDENT'S DENTIST	PHONE
ALLERGIES / MEDICAL CONDITIONS (Please explain checked items):			
Food Allergies _____		Medical Problems _____	
Insect Bite / Sting _____		Medications Taken at Home _____	
Drug Allergies _____			
I give permission for my child, in case of an emergency, to be taken to a physician or hospital by either a parent in charge or by school personnel. I understand that every effort will be made to contact me. If I cannot be reached, I hereby give permission to the physician selected by the teacher in charge or adult chaperone to hospitalize and secure proper treatment (including surgery) for my son/daughter. I am the responsible party for physician/hospitalization payment.			
My child should receive Benadryl for mild allergic reactions My child should not receive Benadryl for the following reasons: _____			
My child should receive an Epi Pen for severe allergic reactions (anaphylaxis) My child should not receive an Epi Pen for the following reasons: _____			
SIGNATURE OF PARENT/GUARDIAN			DATE

Please list those people who have permission to pick your child up from school:

1. \_\_\_\_\_  
     NAME PHONE (*home and cell*)
2. \_\_\_\_\_  
     NAME PHONE (*home and cell*)
3. \_\_\_\_\_  
     NAME PHONE (*home and cell*)
4. \_\_\_\_\_  
     NAME PHONE (*home and cell*)

Please describe your INCLEMENT WEATHER/CRISIS plan in case of early dismissal from school (include names and cell phone numbers if different from your emergency numbers).

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