Trinity Lutheran School
Emergency Information Form

(Please fill in all information completely)

STUDENT NAME_____ Birthdate_____ Grade _____

Home Address_____ City_____ Zip_____

Home Phone #_____

FATHER/GUARDIAN _____

Home address_____

City_____ Zip_____

Home phone #_____

E-mail address_____

Cell #_____

Work #_____

Employer_____

Address_____

City/St./Zip_____

MOTHER/GUARDIAN _____

Home address_____

City_____ Zip_____

Home phone #_____

E-mail address_____

Cell #_____

Work #_____

Employer _____

Address_____

City/St./Zip_____

Persons to be notified in an Emergency, to whom child may be released when a parent is not available.

Name _____ Relationship _____

Address _____ City _____ Zip_____

Home # _____ Work # _____ Cell # _____

Name _____ Relationship _____

Address _____ City _____ Zip_____

Home # _____ Work # _____ Cell # _____

Name _____ Relationship _____

Address _____ City _____ Zip_____

Home # _____ Work # _____ Cell # _____

I give permission to Trinity Lutheran School to secure emergency medical and/or emergency surgical treatment for the above named minor child when necessary.

_____ _____

(Signature of Parent or Guardian) (Date Signed)

_____ _____

(Name of Child's Physician or Health Clinic) (Physician Phone Number)

_____ _____

(Address of Child's Physician or Health Clinic) (Hospital Preferred for Emergency Treatment)

_____ _____

(Health Insurance Policy Name) (Policy Number)

ALLERGIES _____

Date of Last Tetnus Shot _____

Special Health Concerns and Instructions _____

_____

Web/Forms/Revised 8-1-11