

**ST. JOHN'S LUTHERAN SCHOOL
EXTENDED SCHOOL PROGRAM
EMERGENCY CONTACT AND MEDICAL INFORMATION**

_____ CHILD'S NAME		_____ DATE OF BIRTH		M F SEX
_____ PARENT'S/GUARDIAN'S NAME		_____ PARENT'S/GUARDIAN'S NAME		
() _____ HOME PHONE	() _____ WORK PHONE	() _____ HOME PHONE	() _____ WORK PHONE	
() _____ CELL PHONE	() _____ OTHER	() _____ CELL PHONE	() _____ OTHER	
_____ ADDRESS		_____ ADDRESS		
_____ CITY, STATE ZIP CODE		_____ CITY, STATE ZIP CODE		

ALTERNATE EMERGENCY CONTACTS

_____ PRIMARY EMERGENCY CONTACT		_____ SECONDARY EMERGENCY CONTACT	
() _____ HOME PHONE	() _____ WORK PHONE	() _____ HOME PHONE	() _____ WORK PHONE
_____ ADDRESS		_____ ADDRESS	
_____ CITY, ST ZIP CODE		_____ CITY, ST ZIP CODE	

THE PERSONS LISTED ABOVE ARE AUTHORIZED TO PICK UP MY CHILD AND ASSUME MEDICAL RESPONSIBILITY IF I CAN NOT BE REACHED.

MEDICAL INFORMATION

_____ HOSPITAL/CLINIC PREFERENCE	
_____ PHYSICIAN'S NAME	_____ PHONE NUMBER
_____ DENTIST'S NAME	_____ PHONE NUMBER
_____ INSURANCE COMPANY	_____ POLICY NUMBER

ALLERGIES/SPECIAL HEALTH CONSIDERATIONS

I AUTHORIZE ALL MEDICAL AND SURGICAL TREATMENT, X-RAY, LABORATORY, ANESTHESIA, AND OTHER MEDICAL AND/OR HOSPITAL PROCEDURES AS MAY BE PERFORMED OR PRESCRIBED BY THE ATTENDING PHYSICIAN AND/OR PARAMEDICS FOR MY CHILD AND WAIVE MY RIGHT TO INFORMED CONSENT OF TREATMENT. THIS WAIVER APPLIES ONLY IN THE EVEN THAT NEITHER PARENT/GUARDIAN CAN BE REACHED IN THE CASE OF AN EMERGENCY.

_____ PARENT'S/GUARDIAN'S SIGNATURE	_____ DATE
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