

# Trinity Catholic Academy Brockton

## Confidential Student Emergency Information Form

Date \_\_\_\_\_

Student's Name \_\_\_\_\_  
 Last First Middle

Grade \_\_\_\_\_ Room \_\_\_\_\_

Birth Date \_\_\_\_\_

Address \_\_\_\_\_

Place of Birth \_\_\_\_\_

Home Tel. ( ) \_\_\_\_\_

City/Town \_\_\_\_\_ MA Zip \_\_\_\_\_

*Emergencies such as a sudden illness or accident often occur at school. In the event of an emergency, your child will be transported to the nearest local hospital.*

**Please complete the following information:**

\_\_\_\_\_  
 Mother's/Guardian's Name Address City/Town Zip ( ) \_\_\_\_\_  
 Cell Tel. \_\_\_\_\_

\_\_\_\_\_  
 Father's/Guardian's Name Address City/Town Zip ( ) \_\_\_\_\_  
 Cell Tel. \_\_\_\_\_

Child lives with Both ( ) Father ( ) Mother ( ) Guardian ( )

Mother's/Guardian's Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_

Address \_\_\_\_\_ City/Town \_\_\_\_\_ Tel. ( ) \_\_\_\_\_

Father's /Guardian's Occupation \_\_\_\_\_ Place of Employment \_\_\_\_\_

Address \_\_\_\_\_ City/Town \_\_\_\_\_ Tel. ( ) \_\_\_\_\_

Please arrange for **three other** responsible adults to care for your child in the event that you cannot be reached.

Name \_\_\_\_\_ Address \_\_\_\_\_  
 City/Town \_\_\_\_\_ Tel. ( ) \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_  
 City/Town \_\_\_\_\_ Tel. ( ) \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_  
 City/Town \_\_\_\_\_ Tel. ( ) \_\_\_\_\_

**Please indicate if there are any parental restrictions** (e.g., current retraining order)

**Please indicate if your child has had** Chicken pox \_\_\_ German measles \_\_\_ Tuberculosis \_\_\_  
 Please indicate if your child wears Hearing aid(s) \_\_\_ Glasses \_\_\_ Dentures or partial plates \_\_\_

List any **medications**, or **chronic health conditions** such as eye or ear problems, heart disease, diabetes, asthma, allergies\*, seizure disorder, etc.

Explanation \_\_\_\_\_

**\*Indicate all allergies** (be specific) \_\_\_\_\_

Physician's Name \_\_\_\_\_ Address \_\_\_\_\_ Tel. ( ) \_\_\_\_\_

Health Insurance \_\_\_\_\_ Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Has your child had a physical exam within last two years \_\_\_ yes \_\_\_ no Date \_\_\_\_\_

Last dental visit Date \_\_\_\_\_

**I give permission for the School Nurse to share medical information with the appropriate school personnel and to contact my child's physician as necessary.**

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

List other children living in the home.

First Name	Last Name	Date of Birth	Name of School	Grade