Espirito Santo Parochial School

143 Everett Street, Fall River, MA 02723

Emergency Contact & Health Information

Father's Name: _____

Father's Occupation: _____

Name of Company: _____

Business Address: _____

Business Phone: _____

Cell Phone: _____

Email Address: _____

Address of Non-Custodial Parent:
(Legal Documents Required for Student File)

_____

Mother's Name: _____

Mother's Occupation: _____

Name of Company: _____

Business Address: _____

Business Phone: _____

Cell Phone: _____

Email Address: _____

Address of Non-Custodial Parent:
(Legal Documents Required for Student File)

_____

List available relatives/friends who could assume temporary care of your student(s) should you not be available (attach additional if needed):

Name: _____

Relation: _____

Phone: _____

Name: _____

Relation: _____

Phone: _____

Name: _____

Relation: _____

Phone: _____

Are there any individuals who are restricted from picking up your student(s)? _____Yes _____No
(Legal Documents Required for Student File)

Name: _____

Relation: _____

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Please fill in the following information, which is important in the case of serious illness or emergency. Please notify the school of any changes in student(s) health history or changes in medication.

Health Insurance Company: _____ Policy#: _____

Does your student(s) have any allergies? _____Yes _____No

Please detail here:

_____

_____

Is your student affected by any health issues, that the school should be aware of? ___Yes ____No

Please detail here:

_____

_____

Is your student currently any medications, that the school should be aware of? ___Yes ____No

Please detail here:

_____

_____

In case of an emergency, the school will attempt to contact parent/guardian before calling student's primary care provider (physician). Your child will be transported by ambulance to an emergency care facility if necessary.

Physician's Name: _____ Phone#: _____

Dentist's Name: _____ Phone#: _____

A written order from a doctor AND parent is necessary if medication is to be taken in school. Aspirin, cough drops, and/or over-the counter medication cannot be given unless above orders and medication are provided by parent/guardian, in original packaging, or Rx bottle. Please contact the main office for these forms.

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I give permission to the school to share this information relevant to my student(s) health condition with appropriate school personnel when needed to meet my student(s) health safety needs and to exchange information with my student(s) primary care physician for the purpose of referral, diagnosis, and treatment.

Parent Signature: _____ Date: _____

Parent Signature: _____ Date: _____