Espirito Santo Parochial School

143 Everett Street, Fall River, MA 02723

Family and Emergency Information

Student's Name:

1. _____ Grade_____ Date of Birth ____/____/_____

2. _____ Grade _____ Date of Birth ____/____/_____

3. _____ Grade _____ Date of Birth ____/____/_____

Address: _____ City/State: _____ Zip: _____

Home Phone: (____) -_____-_____ Parent's Email: _____

Student(s) lives with: _____ Guardian: _____

Religion: _____ Church: _____ City/State: _____

Father's Name: _____ Mother's Name: _____

Cell Phone: _____ Cell Phone: _____

Email: _____ Email: _____

Father's Occupation: _____ Mother's Occupation: _____

Employer: _____ Employer: _____

Business Address: _____ Business Address: _____

Business Phone: _____ Business Phone: _____

Name of Non-Custodial Parent: _____

Address: _____ City/State: _____

List two available relative/friends who could assume temporary care should you not be available.

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

*Are there any individuals who are restricted from picking up your son/daughter? ____Yes ____No
If Yes, Legal documents are required for student's file.

Name: _____ Relation to Child: _____

Official Parent Signature: _____ Date: _____

(Over Please)

Health Information

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 medication. Refer to student by the number listed on the front page of this document.

Health Insurance Company: _____ Policy #: _____

Allergies: ____Yes ____ No Please specify: _____

Student Name/Number: _____

Describe allergic reactions: _____

Please check and number all that apply to your child(ren):

____ Heart Condition ____ Diabetes ____ Asthma ____ Seizure Disorder

____ Migraines ____ Depression ____ ADD/ADHD

____ Hearing Problems (specify) ____ Left Ear ____ Right Ear ____Hearing Aids

____ Vision Problems (specify) ____ Eyeglasses ____ Contact Lenses

Can your child(ren) participate in our physical education program? ____ Yes ____ No
If No, please explain and include child's name. _____

Please list all medications your child takes:

Child Name: _____ Medication: _____

Child Name: _____ Medication: _____

In case of an emergency, the school will attempt to contact parent/guardian before calling the 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 at school. Aspirin, cough drops, and/or any over-the-counter medication CANNOT be given unless orders and medications are provided by parent/guardian. Please contact the school for appropriate forms.

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

Parent/Guardian Signature: _____ Date: _____