NOTRE DAME ACADEMY

A SISTERS OF UNION-CHRÉTIENNE DE SAINT CHAUMOND SCHOOL

EXTENDED DAYCARE EMERGENCY FORM

FAMILY NAME: _____

CHILDREN:

Name: _____ Grade: _____ Name: _____ Grade: _____

Name: _____ Grade: _____ Name: _____ Grade: _____

Name: _____ Grade: _____ Name: _____ Grade: _____

Home Address: _____ _____ _____
Street *City* *State* *Zip*

IN CASE OF ACCIDENT OR EMERGENCY, please notify:

Name of Father: _____ Cell: ( ) _____ Work: ( ) _____

Guardian: _____ Cell: ( ) _____ Work: ( ) _____

Name of Mother: _____ Cell: ( ) _____ Work: ( ) _____

Guardian: _____ Cell: ( ) _____ Work: ( ) _____

Email: _____

If we cannot be reached, we wish the fol1owing person/s to be notified. We authorize each of them to act in our absence and to pick up our chi1dren, as necessary. They have agreed to comply with the rules of the school.

Name	Relationship	Telephone

(1) _____

(2) _____

(3) _____

Please provide the medical information requested below
with specific instructions regarding allergies or health conditions for your child.
PARENTS ARE RESPONSIBLE FOR PAYMENT OF TREATMENT NOT COVERED BY SCHOOL INSURANCE.

Family physician: _____ Tel: _____

Other physician of choice: _____ Tel: _____

Hospital_____

Allergies:

_____

Health Problems/Concerns:

_____

Eye Glasses: ___YES ____NO Contact Lenses:____ YES____ NO

Please inform the School Office of any changes that occur during the School Year.

IN THE EVENT OF A MEDICAL EMERGENCY I (WE) CONSENT TO THE DECISION MADE BY THE SCHOOL AND ITS AGENTS RELATING TO THE PROVISION OF MEDICAL ASSISTANCE.

Signature of Parent / Guardian: _____

Date: _____

Relationship to the Student: _____