

2009-2010
FAMILY EMERGENCY CARE FORM
 Our Savior Lutheran School & Childcare

Please read carefully, then fill out the following to aid us in safeguarding the health and safety of your child(ren).

Please notify the school immediately of any changes.

Last Name _____ First Name _____ DOB _____ Sex: __ Grade ____
 (If attending OSL) Second child _____ DOB _____ Sex: __ Grade ____
 Third child _____ DOB _____ Sex: __ Grade ____

Address _____ City _____ State ____ Zip _____ Home Phone _____

Mother/Guardian's Name _____ Mother's Cell Phone _____
 Employer _____ Work Phone _____
 E-Mail _____ Pager _____

Father/Guardian's Name _____ Father's Cell Phone _____
 Employer _____ Work Phone _____
 E-Mail _____ Pager _____

Marital Status: Married __ Divorced __ Separated __ Remarried __ Single Parent __ Widow(er) __ Other __

Parent or guardian to be notified first during an EMERGENCY: _____

Name **two** other persons (local contact) in case of serious illness or accident and are unable to reach the parents/guardians:
 Name Address Phone Relationship

Please talk to these individuals and inform them of this matter

Name of Physicians and dentist to be called in any emergency:

Physician _____ Address _____ Phone _____
 Dentist _____ Address _____ Phone _____
 Hospital _____ Address _____ Phone _____
 Family Insurance _____ Policy # _____

List any special problems that your child may have, such as allergies, existing illness, previous serious illness, and injuries during the past 12 month, any medication prescribed for long-term continuous use, and any other information, which the staff should be aware of:

Current medications _____ Blood Type _____

Individual to whom the child(ren) may be released:

| NAME | RELATIONSHIP TO CHILD(REN) | DRIVER'S LICENSE # |
|-------|----------------------------|--------------------|
| _____ | Father/Guardian | _____ |
| _____ | Mother/Guardian | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

MEDICATION

I hereby grant permission for my child(ren) to receive the correct dosage of Benadryl for allergic reactions to insect bites. I hereby grant permission for my child(ren) to receive an antibiotic ointment for a cut or scratch. My child(ren) has no known allergies to any antibiotic ointment.

Signature of parent/legal guardian _____ Date: _____

