

Archbishop Carroll High School

Student I.D. # _____

PLEASE PRINT

Emergency Information Card

Student's Name _____ Homeroom _____
 Address _____ Home Phone _____
 _____ Date of Birth _____

OTHER IMPORTANT PHONE NUMBERS

Mother Cell Number _____ Work Number _____
 Father Cell Number _____ Work Number _____

Parent E-Mail address _____

May the school nurse administer:

- 1. Ibuprofen (Advil) Yes ___ No ___
- 2. Tums Yes ___ No ___
- 3. Acetaminophen (Tylenol) Yes ___ No ___

Allergies to any drug, insect bite, food, etc. requiring medication or hospitalization?
 Yes ___ No ___ If so, what medication? _____

Please indicate any other medical condition(s). _____

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List two neighbors or nearby relatives who will assume temporary care of your child if you cannot be reached.

- 1. Name _____ Telephone _____
- 2. Name _____ Telephone _____

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Physician's Name _____

Address _____

Office Phone No. _____

I hereby give my permission for my child to be given emergency treatment in accordance with the school's physician's orders and to be taken to the nearest hospital if necessary.

Signature of Parent or Guardian _____

Date _____