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____

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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_____________________

Physician's Name ____
Address ____
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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________________________