St. Joseph School

Child's Name: _____

Grade: _____

Date: _____

EMERGENCY INFORMATION FOR NURSE'S OFFICE

I/We _____ give my/our permission for my/our child _____ to receive emergency first aid and/or basic care for illness.

Name of Adult Male in Household	Location 8am-4pm	Phone
_____	_____	_____
Name of Adult Female in Household	**Location 8am-4pm**	**Phone**
_____	_____	_____
Name of Other Contact Person/Relationship	**Location 8am-4pm**	**Phone**
_____	_____	_____

Child's Physician: _____ Phone: _____

Child's Dentist: _____ Phone: _____

Hospital Preferred: _____

Allergies or health problems your child may display:

_____

_____

If you have any special requests or instructions, please list them on the back of this paper. Thank you!!

Parent's Signature: _____

271 E. Main Street Dallastown, PA. 17313 717-244-9386 www.stjoesdallastown.org