

Holy Trinity Regional School

245 Main Street Route 28 West Harwich, Ma 02671 (508)432-8216

Family and Emergency Information – 2009-2010 (updated annually)

Student Name _____ Grade _____
(Last) (First) (MI)

Address _____
(No.) (Street) (City/Town) (Zip)

Date of Birth _____ Male ___ Female ___ Social Security Number (optional) _____

Phone _____ Email _____ Fax _____

Religion _____ Parish _____

City/Town of Parish _____

Student lives with _____ Guardian _____ (if applicable)

Race (optional – used to provide information for yearly statistical reports) _____

Father's Name _____
(First) (Last)

Mother's Name _____
(First) (Last)

Religion _____

Religion _____

Parish _____

Parish _____

Address _____

Address _____

Phone _____

Phone _____

Father's Occupation _____

Mother's Occupation _____

Title or Position _____

Title or Position _____

Name of Company _____

Name of Company _____

Business Address _____

Business Address _____

Business Phone _____

Business Phone _____

Cell Phone _____

Cell Phone _____

E-Mail _____

E-Mail _____

Other siblings presently attending Holy Trinity Regional School

1. _____ Grade _____ 2. _____ Grade _____

List two available neighbors/relatives who could assume temporary care of your son/daughter should you be unavailable.

Name _____ Relation _____

Address _____ Phone _____

Name _____ Relation _____

Address _____ Phone _____

(Over)

Are there any individuals who are restricted from picking up your son/daughter? _____

Name of individual _____ Relationship to child _____

Official Parent Signature _____

Health Information

Health Update for _____ Grade _____

Please fill in the following information, which is important in the case of serious illness or emergency. Please notify the school nurse of any changes in student health history or changes in medication.

Health Insurance Company _____ Policy Number _____

If allergies exist, please describe the specific allergic reaction:

Allergies to environment _____

Allergies to food _____

Allergies to medication _____

Vision problems _____ Glasses _____ Contacts _____

Hearing problems _____

Illness, injuries, or surgery since last year? _____ If yes, please describe.

List medications taken on a regular basis, dosage, and time taken and reason that the medication is taken.

Medication	Dose	Time Taken	Reason for taking medication
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Please refer to medication administration policy in the student handbook. Medication forms are needed for any medication given to students at school.

Is there any additional information that the school nurse should be aware of? Please explain.

In case of accident or serious illness, and I am unable to be contacted, the school will call the physician named below and follow his instructions. If it is impossible to contact the physician, the school will make whatever arrangements are deemed necessary.

Name of Physician _____ Phone _____

Address _____

I give permission for the school nurse to share pertinent medical information with the school staff.

Parent/Guardian Signature _____ Date _____