

*** PLEASE PRINT ALL INFORMATION LEGIBLY ***



School year 20__ / 20__

FAMILY EMERGENCY INFORMATION

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*This form is very important to you and to the school in case of an emergency, illness, or accident.
Please complete the following information and return **immediately**.*

Main Name: _____ **Phone #:** _____

In the space below, please list your child or children according to grade. The column on the right should be used to indicate any **allergies*** or **medical conditions**** they may have and the related treatment(s) of which the school should be aware.

* **Allergies** may include but not be limited to: latex, penicillin, grass, dust, mold, pollen, insect bites, etc.
** **Medical conditions** may include but not be limited to: asthma, heart murmur, ear tubes, diabetes, etc.

Child(ren) Name(s)	Grade	Allergies/Medical Conditions	Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Below are several possible courses of action the school will take should your child(ren) be the subject of a medical emergency. Please rank each item in the order of importance in which you would like the school to act.

NOTE: IT IS CRITICAL TO NOTIFY THE SCHOOL OF ANY CHANGE TO THE PHONE NUMBERS LISTED BELOW.
****Use numbers 1-5 to assign importance to each course of action: 1 = First, 5 = Last**

IN CASE OF AN EMERGENCY, THE SCHOOL IS AUTHORIZED TO PROCEED AS INDICATED BELOW			
<input type="checkbox"/>	Contact Mother:	_____	_____
		Cell	Home Work
<input type="checkbox"/>	Contact Father:	_____	_____
		Cell	Home Work
<input type="checkbox"/>	Contact Family Physician:	_____	_____
		Name	Phone #
<input type="checkbox"/>	Take child to ER:	_____	_____
		Hospital Name	Phone #
<input type="checkbox"/>	Other desired procedure:	_____	

List any other available contacts and their phone numbers. Specify name and relationship to student(s).

Name	Relationship	Phone #
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____