Emergency Contact Form

PLEASE FILL OUT ONE FORM PER FAMILY (INCLUDE ALL ENROLLED CHILDREN)

School Year: _____

Child's Full Name _____ Grade _____ Birth Date ____/____/_____

Child's Full Name _____ Grade _____ Birth Date ____/____/_____

Child's Full Name _____ Grade _____ Birth Date ____/____/_____

Child's Full Name _____ Grade _____ Birth Date ____/____/_____

Child(ren)'s Home Address: _____
Street/Apt. # **City** **State** **Zip Code**

Parent/Guardian Name(s):	Relationship:	Cell:	Work/Other (specify):	Email:

Name of person(s) (other than parents) authorized to pick up child(ren) or who can be contacted in case of emergency:

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Child's Physician: _____ **Phone**: _____

Address: _____
Street/Apt. # **City** **State** **Zip Code**

In an **EMERGENCY** requiring immediate medical attention, your child will be taken to the **NEAREST HOSPITAL EMERGENCY ROOM**. Your signature authorizes Grace Classical Academy and its representatives to transport your child and give consent to obtain emergency medical treatment in case of any illness or injury in connection with a school activity or school trip. Such treatment will be administered by physicians, other medical personnel, hospitals, and/or clinics selected by Grace Classical Academy or its representatives.

Signature of Parent/Guardian _____ **Date** _____/_____/_____