St. Martin's Lutheran School of Annapolis
Emergency Contact Information

The following emergency information is required for each student on a separate form. Please print clearly and return to school. It is very important that we have complete student information and contact phone numbers

Student Name: _____ DOB: _____ Grade: _____ Age: _____

Home Address: _____

Medical History

Please list any medical conditions, medical information or allergies St. Martin's should be aware of:

_____

_____

Is the student currently taking any medications: Yes _____ No _____

If yes, please list: _____

Does your child require an EpiPen? Yes _____ No _____

Does your child require an inhaler? Yes _____ No _____

Parent/Guardian Contact Information

Parent/Guardian Name: _____ Employer: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Parent/Guardian Name: _____ Employer: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

SAINT MARTIN'S
SCHOOL OF ANNAPOLIS

Emergency Contacts

Name: _____ Relationship to Student: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Name: _____ Relationship to Student: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Authorized Pickup Persons

Name: _____ Relationship to Student: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Name: _____ Relationship to Student: _____

Cell Phone: _____ Work Phone: _____ Home Phone: _____

Note: If you intend for your child to be picked up by someone other than those listed above, please email the school as soon as possible: schooloffice@stmartinsonline.org.

Authorization for Emergency Medical Care

In emergencies requiring immediate medical attention, your child will be taken to the nearest hospital emergency room. Your signature authorizes a responsible person to have your child transported.

I, _____, hereby authorize medical care for my child, _____, if, in the judgement of the staff, treatment for any injury or illness. I also authorize the administering of anesthetics and/or any other procedures deemed necessary by the healthcare provider or attending physician. I understand that I will be notified at the earliest possible time should prior notice prove impossible. I understand that I am financially responsible for any expenses involving medical care and transportation incurred on behalf of my child.

Parent/Guardian Name: _____ Parent/Guardian Signature: _____

Date: _____ Health Insurance Carrier: _____

Group Number: _____ ID Number: _____