Please fill out BOTH SIDES of this form.

DIOCESE OF ALLENTOWN
St. Theresa Preschool
Emergency Information 2026-2027

1. FAMILY INFORMATION

Student Name _____ Grade _____
Address _____City _____ State _____ Zip _____
Telephone Number _____ E-Mail Address _____
Date of Birth _____ Place of Birth _____
Public School District _____

2. PARENT/GUARDIAN INFORMATION

Student lives with (circle one) Parents Mother Father Other _____
Father/Guardian's Name _____ Home Telephone _____
Employer _____ Work Telephone _____ Ext. _____
Cell Phone Number _____ E-Mail _____
Mother/Guardian's Name _____ Home Telephone _____
Employer _____ Work Telephone _____ Ext. _____
Cell Phone Number _____ E-Mail _____

Parents/Guardians listed above have permission to pick-up the child unless otherwise indicated. Notify the Preschool Director immediately if there are any court orders restricting non-custodial parents or others from contact with the child. Provide the Director with a copy of the court order.

3. CHILD CARE PROVIDER INFORMATION

Those designated below are authorized to pick up my child from the school in an emergency.
Child Care Provider's Name _____ Relationship to the Child _____
Telephone Number _____ Work Telephone _____ Ext. _____
Cell Phone Number _____ E-Mail _____

4. LOCAL CONTACT INFORMATION

1.Child Care Provider's Name _____ Relationship to the Child _____
Home Telephone Number _____ Work Telephone _____ Ext. _____
Cell Phone Number _____ E-Mail _____
2.Child Care Provider's Name _____ Relationship to the Child _____
Telephone Number _____ Work Telephone _____ Ext. _____
Cell Phone Number _____ E-Mail _____

5. MEDICAL/PHYSICAL INFORMATION

Doctor's Name _____ Telephone Number _____
Hospital Preference _____ Second Choice _____
Insurance Company _____ Policy No. _____ Group No. _____
Dentist's Name _____ Telephone Number _____

In a medical emergency, we hereby authorize the Preschool to seek emergency medical assistance for our child if we cannot be reached.

_____ _____ _____
Parent/Guardian Signature Parent/Guardian Signature Date

Please keep a copy of this form for your records. IMPORTANT: Please update the Preschool immediately if any information changes.

STUDENT HEALTH INFORMATION

Student's Name _____ Date of Birth _____
Grade/Teacher _____/_____ Cell Phone _____

Does your child have a history of any of the following conditions? If so, Please explain type of medical treatment.

YES	NO	
_____	_____	ADD/ADHD _____
_____	_____	Asthma _____
_____	_____	Diabetes _____
_____	_____	Food or Drug Allergy_____
_____	_____	Bee Sting Allergy _____
_____	_____	Seizure Disorder _____
_____	_____	Condition Limiting Physical Education _____
_____	_____	Migraine Headaches _____
_____	_____	Other Chronic or Recurrent Conditions _____
_____	_____	Glasses (When to be Worn) _____
_____	_____	Presently Taking Medications

Names of Medication	Reasons for Taking Medication
_____	_____
_____	_____
_____	_____
_____	_____

In the event that my child should become seriously ill or injured while in school and require prompt emergency care, I give my permission to the attending physician for any necessary emergency medical treatment.

_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Signature	Date
_____	_____	_____
Please Print name of Parent/Guardian	Please Print name of Parent/Guardian	Date