ST. MARTIN OF TOURS ACADEMY

Est. 1951

FAMILY NAME: _____

Contact Release and Emergency Consent Form

STUDENT'S LAST NAME	FIRST	BIRTH DATE	GRADE

STUDENT'S PRIMARY ADDRESS	CITY	ZIP CODE	PHONE

PRIMARY E-MAIL: _____ **OTHER E-MAIL:** _____

STUDENT LIVES WITH: ☐ BOTH PARENTS ☐ MOTHER ☐ FATHER ☐ GUARDIAN PARISH REGISTERED IN: _____ *(if applicable)*

FAMILY INFORMATION	☐ FATHER ☐ STEP-FATHER ☐ GUARDIAN	☐ MOTHER ☐ STEP-MOTHER ☐ GUARDIAN
NAME		
HOME PHONE *(if different than student)*		
ADDRESS *(if different than student)*		
NAME OF EMPLOYER		
WORK PHONE		
CELL PHONE		
BEST PHONE # DURING SCHOOL HOURS		

THE FOLLOWING MAY RELEASE MY CHILD FROM SCHOOL IN A NON-EMERGENCY SITUATION:

_____ _____ _____

_____ _____ _____

THE FOLLOWING PERSON(S) MAY NOT PICK-UP MY CHILD

PLEASE INDICATE IF A RESTRAINING ORDER IS IN PLACE AND THE EXPIRATION DATE. A COPY MUST BE ON FILE WITH THE SCHOOL OFFICE.

_____ _____

I HEREBY GIVE PERMISSION FOR MY CHILD TO WALK OFF CAMPUS WITHOUT ADULT SUPERVISION AT DISMISSAL TIME AND I ASSUME ALL RESPONSIBILITY FOR HIM/HER AFTER LEAVING SCHOOL. (ONCE THE CHILD HAS LEFT SCHOOL PROPERTY HE/SHE WILL NOT BE ABLE TO RETURN TO SCHOOL.) ☐ YES ☐ NO

FORM COMPLETED BY: _____ **DATE:** _____

Complete Page 2

Family Name:_____

EMERGENCY/RELEASE INFORMATION *Identification may be requested.*

In an event of apparent illness, accident, disaster or emergency when I cannot be reached, I wish one of the following to be notified by telephone. They are authorized to act in my absence. They may also release my child from school. *(list at least two names)*

Name(s): Relation: Phone:

_____ _____ (Daytime)_____(Cell)_____

_____ _____ (Daytime)_____(Cell)_____

_____ _____ (Daytime)_____(Cell)_____

MEDICAL CONSENT / TREATMENT

In the event of an emergency, I hereby give permission to transport my child to a hospital for emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. I also understand that the school does not assume responsibility for payment of a physician.

Doctor	**Phone**	**Address**	**Hospital Preference**
Dentist	**Phone**	**Address**	

MEDICAL INFORMATION:

Does your child(ren) have any unusual health conditions: ☐ yes ☐ no

Student Name: _____

Medical Conditions: (diabetes, epilepsy, heart conditions, etc.)

_____

Allergies:_____

Student Name: _____

Medical Conditions: (diabetes, epilepsy, heart conditions, etc.)

_____

Allergies:_____

Grandparent Addresses (Invitation to Attend Grandparents' Day)

Grandparent(s) first and last names: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Grandparent(s) first and last names:_____
Address: _____
City: _____ State: _____ Zip Code: _____

Great Grandparent(s) or other relative (if one of the above are unavailable):
Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____

Office Use Only - In case of disaster or emergency:

Name: _____ **Was released to:**_____

Name: _____ **Was released to:**_____

Name:_____ **Was released to:**_____

Date: _____ **Time:** _____

Location to which child/children taken: _____ **School official:** _____