OLV Elementary School
A Father Baker Legacy

Emergency Contact Form

Family Name: _____

Mother's Cell #: _____ Father's Cell #: _____

STUDENTS

Name: _____ Grade: _____ Date of Birth: _____

Name: _____ Grade: _____ Date of Birth: _____

Name: _____ Grade: _____ Date of Birth: _____

Name: _____ Grade: _____ Date of Birth: _____

PEOPLE AUTHORIZED TO PICK UP YOUR CHILD/CHILDREN

Name: _____ Relationship: _____

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

Name: _____ Relationship: _____

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

Name: _____ Relationship: _____

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

HEALTH INSURANCE INFORMATION

Insurance Provider: _____

Primary Insurance Carrier: _____ Policy/Group #: _____

EMERGENCY MEDICAL AUTHORIZATION

In the event a reasonable attempt has been made to contact you but we have been unsuccessful we will need your permission to transport your child to any reasonably accessible hospital facility and/or to allow administration of emergency medical treatment by any licensed physician or dentist.

☐ I give my consent
☐ I do not consent and wish you to: _____

_____

_____

Parent Signature: _____ Date: _____