St THOMAS
THE APOSTLE SCHOOL

NEASC Accredited

SHADOW DAY EMERGENCY FORM

This form must be completed by the parent/guardian in case of an accident or medical emergency and must be received by the school at least **one week prior** to the Shadow Day.

Student Information

Name_____ Shadow Date_____

Address_____ Home Phone #_____

City_____ State_____ Zip Code_____

Current School_____ Current Grade_____

Mother's Name_____

Mother's Work #_____ Mother's Cell #_____

Father's Name_____

Father's Work #_____ Father's Cell #_____

Please list any allergies to food, medicine, or any other pertinent health information:

_____

Emergency Contact Information

Please provide two emergency contacts (e.g.: relative, neighbor) in case you cannot be reached.

#1 Contact_____ Telephone # (____) _____

Relationship_____

#2 Contact_____ Telephone # (____) _____

Relationship_____

In case of an emergency, when I cannot be reached by phone, I hereby grant school authorities permission to take my child (name)_____ to any licensed physician, dentist, eye doctor, or hospital. In case of severe bleeding, poisoning, or where artificial respiration is necessary, I give the school permission to take immediate action as necessary.

_____ _____

Signature of Parent/Guardian Date