



# St THOMAS

## THE APOSTLE SCHOOL



### 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