

### Church of Saint Matthew Faith Formation Emergency Contact and Medical Information

1<sup>st</sup> Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ M F

Allergies/Special Needs: medical, learning, physical? \_\_\_\_\_

2<sup>nd</sup> Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ M F

Allergies/Special Needs: medical, learning, physical? \_\_\_\_\_

3<sup>rd</sup> Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ M F

Allergies/Special Needs: medical, learning, physical? \_\_\_\_\_

4<sup>th</sup> Child's Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ M F

Allergies/Special Needs: medical, learning, physical? \_\_\_\_\_

### Parent/Guardian Information

Mother's name/Guardian's Name

Father's name/Guardian's Name

\_\_\_\_\_

\_\_\_\_\_

( ) \_\_\_\_\_  
Home Phone

( ) \_\_\_\_\_  
Work or cell #

( ) \_\_\_\_\_  
Home Phone

( ) \_\_\_\_\_  
Work or cell #

Address

Address

City, ST ZIP Code

City, ST ZIP Code

### Emergency Contacts

**In case of emergency, who should we call first? \_\_\_\_\_ Mother or \_\_\_\_\_ Father**

If we cannot reach either mother or father, who would be your **other emergency** contact?

Name: \_\_\_\_\_

Home Phone # ( ) \_\_\_\_\_ Work or Cell#: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

Relationship to child/children? \_\_\_\_\_

### Waiver Information

*This waiver applies only in the event that neither parent/guardian, nor designated emergency contact, can be reached in the case of an emergency.*

By signing this form, in case of emergency, I hereby authorize a representative from St. Matthew Church to contact 911 and, as recommended by certified emergency personnel (i.e. EMT, First Responder etc.), accompany my child via ambulance to a hospital as recommended by the emergency personnel. I authorize all medical and surgical treatment, x-ray, laboratory, anesthesia and other medical and/or hospital procedures as may be performed or prescribed by the attending physician or emergency personnel for my child and waive my right to informed consent of treatment.

\_\_\_\_\_  
Parent's/Guardian's Signature

\_\_\_\_\_  
Date