Name:_____ **born**: _____ **grade**: _____

EMERGENCY HOME CONTACT CARD - GOOD SHEPHERD EVANGELICAL LUTHERAN SCHOOL
Lutheran Elementary School Year 2016-2017

Dear Parent or Legal Guardian:
The well being of your child is considered very important by our school. Sometimes when children become seriously ill or injured, it can be difficult to locate and contact parents, legal guardians or family physicians. In order to make our health and safety programs more effective, we request your cooperation in filling out this report for your child. Please fill in the appropriate blanks, update any information that has changed and sign the form in the presence of a witness. Your signature indicates that a copy of this form is as valid as an original.

Child's home address:_____
Street City State Zip

Home phone:_____ Primary E-mail Address_____

Father - L/G:_____ Work phone F:_____ Cell F:_____

Mother - L/G:_____ Work phone M:_____ Cell M:_____

Family Physician:_____ Physician's phone:_____

In case of an accident, serious injury or medical problem I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to arrange for medical care.

If, in the opinion of the school staff - Mrs. Barbara Seifert, Teacher, Mrs. Joyce Tafel, Teacher, Mrs. Kim Schuette, Teacher, Pastor Jacob Behnken or Pastor John Seifert emergency medical care is required, I authorize the school to call the ambulance paramedics and/or also arrange for other medical treatment, understanding that the legal responsibility for ambulance conveyance expenses and for medical expenses incurred is a parental one. I have gained the consent of the following adult to assume subsequent, temporary care of my child if I still cannot be reached.

Name:_____ Address_____

Phone:_____ _____

The above-named person may also be called in the case of incidental illness or injury, should I not be able to be reached and emergency care is not required.

The following is a list of my special requests to help aid in my child's care, including a list of any known allergies and present medications.

_____

_____

Date:_____

Medical Carrier: _____ Policy Number: _____

Claims Phone Number: (_____)_____ Insured's name: _____

Date:_____ _____
Signature of parent or legal guardian

Date:_____ _____
Signature of witness