Saint Joseph School
132 High Street
Medford, MA 02155

2023-2024 EMERGENCY and MEDICAL INFORMATION

STUDENT NAME: _____ GRADE: _____

EMERGENCY CONTACT: _____ RELATIONSHIP TO CHILD: _____

CELL PHONE NUMBER: _____ E-MAIL: _____

PERSON(S) AUTHORIZED TO PICK UP CHILD:

NAME: _____ PHONE #: _____

ADDRESS: _____

RELATIONSHIP TO CHILD: _____

NAME: _____ PHONE #: _____

ADDRESS: _____

RELATIONSHIP TO CHILD:_ _____

In case of accident or serious illness, I request the school contact me. If the school is unable to reach me, I hereby authorize the school to call the physician or dentist listed below and to follow his/her instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary.

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE**: _____

MEDICAL INFORMATION

Doctor's Name and Phone #: _____

Dentist's Name and Phone #: _____

Student's Medical History: (Please indicate if the student has any significant medical problems such as asthma, diabetes, heart condition, etc.)

_____

_____

Allergies:

Bee stings, wasps_____
Dairy, eggs _____
Peanuts, tree nuts_____
Penicillin/antibiotics_____
Dust/mold_____
Other (specify): _____

Medications needed (please list): _____

Signature of Parent or Guardian:_____ Date:_____

Nurse's Contact Information: 781/396-3636 ext. 4 mdampolo@sjsmedford.com