



# Our Lady of Lourdes Catholic School

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## Emergency Treatment / Crisis Information 2025-2026

**Must be completed by parent or guardian (one per family please). PLEASE PRINT NEATLY!**

*In the event of a medical emergency or crisis at school, and a parent/guardian cannot be reached, only those you name on this form will be permitted to take responsibility for your child/ren. You are required to notify the school office if any of the following information changes during the school year.*

Family Last Name \_\_\_\_\_

Primary Emergency Phone # \_\_\_\_\_

Home Address (Street/City/Zip): \_\_\_\_\_

Mother/Guardian:

Emergency Phone \_\_\_\_\_

Email:

Business Phone \_\_\_\_\_

Father/Guardian:

Emergency Phone \_\_\_\_\_

Email:

Business Phone \_\_\_\_\_

### Student(s) name(s):

1. \_\_\_\_\_ Grade: \_\_\_\_\_ Medications/Allergies/Health Issues \_\_\_\_\_

2. \_\_\_\_\_ Grade: \_\_\_\_\_ Medications/Allergies/Health Issues \_\_\_\_\_

3. \_\_\_\_\_ Grade: \_\_\_\_\_ Medications/Allergies/Health Issues \_\_\_\_\_

4. \_\_\_\_\_ Grade: \_\_\_\_\_ Medications/Allergies/Health Issues \_\_\_\_\_

Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone \_\_\_\_\_ Hospital preference \_\_\_\_\_

Insurance Company covering child/ren \_\_\_\_\_ Policy# \_\_\_\_\_

**Please list below names of those who will assume responsibility if parent/guardian cannot be reached in an emergency.**

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell \_\_\_\_\_ Home Phone \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell \_\_\_\_\_ Home Phone \_\_\_\_\_

3. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell \_\_\_\_\_ Home Phone \_\_\_\_\_

4. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Cell \_\_\_\_\_ Home Phone \_\_\_\_\_

\_\_\_\_\_

STATE OF FLORIDA, COUNTY OF PINELLAS



*Signature of Parent/Guardian*

*Print Name*

*Date*

The foregoing was acknowledged before me on this \_\_\_\_\_ day of \_\_\_\_\_ 2025  
by \_\_\_\_\_.

Signature of Notary

Date x