



Our Lady of Lourdes Catholic School

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Emergency Treatment / Crisis Information 2026-2027

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 _____ 2026

By _____.

Signature of Notary

Date x