



HOLY FAMILY HIGH SCHOOL
Emergency Information

Student's Name: _____ Birthdate: _____
Parent/Guardian: (Please Print) _____
Father's Phone (Day) _____ Mother's Phone (Day) _____

Emergency Contact: (Provide name (s) of someone local such as a relative or friend if you cannot be reached.)

Name of Primary Contact: _____
Primary Contact Phone (Day): _____ (Circle One: Home, Work, Cell)
Primary Contact Relationship to Student: _____
Name of Secondary Contact: _____
Secondary Contact Phone (Day): _____ (Circle One: Home, Work, Cell)
Secondary Contact Relationship to Student: _____
Physician: _____ Phone Number: _____
Medical Insurance Carrier: _____
Insured Member's Name: _____
Policy Number: _____
Hospital Preference: _____ Phone Number: _____

Student Medical Alert

Chronic Illnesses: _____

Allergies: _____
Medications Taken at Home: _____
Medications Taken at School: _____
Date of Last Tetanus Shot: _____

AUTHORIZATION FOR TREATMENT OF MINORS

I, _____ being the parent or legal guardian of _____
give my consent for emergency medical and surgical treatment of this minor in a licensed hospital by a licensed Colorado Physician
should his/her condition so require it in my absence. I understand that in such a case reasonable attempts would first be made to
contact me, time and conditions permitting. As long as the medical or surgical treatment necessary in the situation is in accordance
with generally accepted standards of medical practice for the particular type of injury or illness involved. I impose no specific
limitations or prohibitions regarding treatment other than those that follow: (If none, so state)

THIS AUTHORIZATION IS EFFECTIVE WHILE ENROLLED AT HOLY FAMILY HIGH SCHOOL

Mother's Signature

Date

Father's Signature

Date