

Name: \_\_\_\_\_ born: \_\_\_\_\_ grade: \_\_\_\_\_

**EMERGENCY HOME CONTACT CARD - GOOD SHEPHERD EVANGELICAL LUTHERAN SCHOOL  
Lutheran Elementary School Year 2009-2010**

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: \_\_\_\_\_

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 (Mr. Timothy Thies, Principal, Mrs. Barbara Seifert, teacher or Mrs. Joyce Tafel, teacher, Pastor Jonathan D. Quinn, Pastor John C. 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 not be 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