



402 S. Ballenger Highway
Flint, Michigan 48532
Phone: 810-239-6733
Fax: 810-239-5466

SUMMER EMERGENCY CONTACT INFORMATION 2024

Student's Name _____
Last First M.I. Date of Birth Sex: M/F Grade

Student's Name _____
Last First M.I. Date of Birth Sex: M/F Grade
(2nd Child)

Student's Name _____
Last First M.I. Date of Birth Sex: M/F Grade
(3rd Child)

Father/Guardian's Name _____ Social Security Number ____ - ____ - ____
Place of Employment _____ Occupation _____
Business Phone _____ Cell Phone _____ Okay to Call? Yes / No
Email Address: _____

Mother/Guardian's Name _____ Social Security Number ____ - ____ - ____
Place of Employment _____ Occupation _____
Business Phone _____ Cell Phone _____ Okay to Call? Yes / No
Email Address: _____

Marital Status of Parents: ____ Single ____ Married ____ Divorced ____ Widowed

Street Address _____ Home Phone _____

City _____ ZIP Code _____ E-mail _____

Name of Custodial Parent or Guardian (if applicable) _____

Names of persons to be notified in an emergency when parent is not available. Also, indicate if they may pick up child(ren) after school. Please list relationship to child.

1. Name _____ Relationship: _____ Phone _____ Alternate Phone _____

Check one or both: _____ Emergency Contact _____ Pick-up

2. Name _____ Relationship: _____ Phone _____ Alternate Phone _____

Check one or both: _____ Emergency Contact _____ Pick-up

3. Name _____ Relationship: _____ Phone _____ Alternate Phone _____

Check one or both: _____ Emergency Contact _____ Pick-up

4. Name _____ Relationship: _____ Phone _____ Alternate Phone _____

Check one or both: _____ Emergency Contact _____ Pick-up

Name(s) of person(s) to whom child(ren) **MAY NOT** be released (per Court Order on file):

Health Information

Physician's Name _____ Phone _____

Preferred Hospital _____

Insurance Carrier _____ Group # _____ Contract # _____

Current Continuing Medication(s) _____

Any OTC or prescription medications to be administered at school must be accompanied by a form signed by the physician and a parent/guardian.

Last Tetanus Shot _____

Child's Name _____ **Date** _____

Child's Name _____ **Date** _____

Child's Name _____ **Date** _____

Any other health information the school should know (allergies, etc.) _____

****New students must have a copy of birth certificate, immunizations, and health appraisal due at time of enrollment ****

I herby give my permission to St. Paul Lutheran School to secure emergency medical and/or emergency surgical treatment for the child(ren) named on this form while in the school's care.

Signature of Parent or Guardian _____ Date _____