



Incarnate Word Academy

Student Emergency Form (2021-2022)

Student Name: \_\_\_\_\_  
*Last First Middle*

Birth Date: \_\_\_\_\_ Year: Fr \_\_\_\_ / So \_\_\_\_ / Jr \_\_\_\_ / Sr \_\_\_\_

Address: \_\_\_\_\_ City/State/Zip: \_\_\_\_\_

Student Cell Phone: \_\_\_\_\_ Home Phone: \_\_\_\_\_

**Emergency Contact Information**

Mother: Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

Street

City

State

Zip Code

Father: Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

Street

City

State

Zip Code

List person(s) to be contacted in case of emergency when parent/guardian cannot be reached.

Name

Phone Number

Relationship

**Private (Primary) Insurance Information**

Ins. Co. Name \_\_\_\_\_ Pre-authorization Phone # \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Name of Insurance Policy Holder \_\_\_\_\_ Date of Birth \_\_\_\_\_

Policy Holder's Employer \_\_\_\_\_

Employer's Complete Address \_\_\_\_\_

Policy Holder's SS# \_\_\_\_\_ Group # \_\_\_\_\_ Policy # \_\_\_\_\_ ID/other # \_\_\_\_\_

Insurance Plan: \_\_\_\_ HMO \_\_\_\_ PPO \_\_\_\_ N/A My daughter is covered by the above policy: \_\_\_\_ Yes \_\_\_\_ No.

**Health Information**

List any health conditions such as heart disease, diabetes, epilepsy, severe allergies, allergies to medications, eye or ear problems, or any chronic conditions:

List medications being taken: \_\_\_\_\_

Food Allergies

Doctor Name: \_\_\_\_\_ Office Phone #: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

*Hospital Name*

*Address*

*Phone#*

I, the undersigned, do hereby authorize school administration to render first aid for illness or injury to my daughter named above. In the event of a medical emergency, I authorize school administration to have my daughter transported to the nearest hospital/emergency care center for emergency medical or surgical treatment and to contact my daughter's physician and one of the persons listed above. I further authorize the release of the above medical information to all medical personnel providing treatment. I agree to be solely responsible for the payment of all expenses incurred in such an emergency. I do hereby release, hold harmless and indemnify Incarnate Word Academy and any other of their officers, agents, employees or representatives ("Released Parties") from any and all liability, claims, losses or expenses arising from personal injury, death, or loss of or damage to property arising from any medical treatment received and/or transportation to the nearest hospital/emergency care center. This form may be signed in counterparts and may be delivered by facsimile or other electronic means, each of which may be deemed an original, and all of which together constitute one and the same agreement.

**Parent Signature (First, Middle, and Last Name):** \_\_\_\_\_ **Date:** \_\_\_\_\_