

# CHRIST THE CORNERSTONE ACADEMY EMERGENCY CONTACT

Student's Name \_\_\_\_\_ 2010-2011- Grade \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip Code \_\_\_\_\_

**PLEASE PRINT**

*(Please update any changes immediately)*

**EMERGENCY CONTACTS:**

**Emergency Contact Person #1:** Name \_\_\_\_\_  
*(Parent or Guardian)*

Relationship: \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Pager # \_\_\_\_\_

Email address \_\_\_\_\_

**Emergency Contact Person #2:** Name \_\_\_\_\_  
*(Parent or Guardian)*

Relationship: \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_ Pager # \_\_\_\_\_

Email address \_\_\_\_\_

**Emergency Contact Person #3:** Name \_\_\_\_\_

Relationship: \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work Phone# \_\_\_\_\_

Cell Phone# \_\_\_\_\_ Pager # \_\_\_\_\_

**Emergency Contact Person #4:** Name \_\_\_\_\_

Relationship: \_\_\_\_\_ Home Phone # \_\_\_\_\_ Work Phone# \_\_\_\_\_

Cell Phone# \_\_\_\_\_ Pager # \_\_\_\_\_

**CONSENT FOR MEDICAL TREATMENT:**

As the Parent, Agency Representative or Legal Guardian, I hereby give consent to CHRIST THE CORNERSTONE ACADEMY to provide all emergency dental or medical care prescribed by a duly licensed physician (M.D.),

Osteopath (D.O.) or dentist (D.D.S.) for \_\_\_\_\_ . This care may be given under whatever conditions are necessary to preserve the life, limb or well being of my dependent.

Medical Group or Record# \_\_\_\_\_

Name of Physician: \_\_\_\_\_ Office Phone# ( ) \_\_\_\_\_

Child has the following medication allergies: \_\_\_\_\_

\_\_\_\_\_  
Signature of Parent/Agency Representative/Guardian

\_\_\_\_\_  
Date

Home Phone# ( ) \_\_\_\_\_ Work Phone# ( ) \_\_\_\_\_