

D.O.B. \_\_\_\_\_

**Our Lady of the Lake School**  
**26 Lakeside Avenue**  
**Verona, NJ 07044 Phone 973-239-1160**  
**EMERGENCY REFERENCE**

Pupil \_\_\_\_\_ SS# \_\_\_\_\_ Grade \_\_\_\_\_  
(Last) (First)

Home Address: \_\_\_\_\_ Phone \_\_\_\_\_

Father: \_\_\_\_\_ Business Name \_\_\_\_\_ Phone \_\_\_\_\_

Mother: \_\_\_\_\_ Business Name \_\_\_\_\_ Phone \_\_\_\_\_

Father Cell Phone \_\_\_\_\_ Mother Cell Phone \_\_\_\_\_

ONLY 1 EMAIL ADDRESS FOR EMERGENCY \_\_\_\_\_

Name and Phone# of 2 reliable persons who are available (with transportation) to be called if parent unavailable

1. \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

2. \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Please list other children in the family:

<u>Name</u>	<u>Date of Birth</u>	<u>School Attending</u>

1. Has your child had any serious illness, injury, operation or communicable disease in the past 2 Years? \_\_\_\_\_

2. Does your child have any allergies? \_\_\_\_\_ Specify \_\_\_\_\_

Course of treatment \_\_\_\_\_

3. Family Physician to be called if necessary: Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Day Off \_\_\_\_\_

Hospital of Choice \_\_\_\_\_ Permission to treat in emergency: Yes \_\_\_ No \_\_\_

4. Is child taking a special medication or using a special aid? If so, please specify \_\_\_\_\_

\_\_\_\_\_

5. Serious allergy or condition: \_\_\_\_\_

Emergency Treatment \_\_\_\_\_

\_\_\_\_\_

6. Please state any additional information which would benefit your child's health and be helpful to the school team (including dietary restrictions, physical limitations or restrictions, etc.) to provide special care: \_\_\_\_\_

\_\_\_\_\_

7. I give permission for my child's health information to be disclosed to appropriate school employees who have a legitimate health interest in my child.

**DATE** \_\_\_\_\_ **SIGNED** \_\_\_\_\_