Washington Jesuit Academy
EMERGENCY INFORMATION FORM
2018-2019

Student Name____ **Date of Birth** ___________________**Grade** ____________

Home Address: ____**Social Security Number**________________

Mother/Guardian Father/Guardian

Name: ____ **Name:**____

Home Phone: ____________________________________ **Home Phone:** ____

Work Phone: ____________________________________ **Work Phone:** ____

Cell Phone: ______________________________________ **Cell Phone:** ____

E-Mail:____ **E-Mail:**____

Emergency Contact

Name: ______________________________________ **Relationship to Student:** _____________________________

Home Phone:________________________________**Work Phone:**_____________________**Cell Phone:**__________________

Student's Physician's Name:____**Phone:**_____________________

Medical Information

Food allergies/sensitivies____

Existing Medical Problems____

Medications child is taking____

Additional Comments____

____

Medical Insurance Information

Subscriber:_______________________________ **Subscriber Relationship to child**___________________________________

Policy/Group#______________________________________

Medical Insurance Co. Name and Phone Number:____

Permission for Medical Treatment

In the event that Washington Jesuit Academy is unable to reach any of the individuals named above promptly by phone, I/we authorize a WJA representative to seek and to secure any emergency medical or surgical care for my/our child.

I/we agree to be personally responsible for the payment of such medical expenses incurred. I/we authorize any charges to be billed to my/our insurance company. I/we further authorize the facility at which surgical or medical care is rendered to release all necessary information to my/our insurance company for purposes of reimbursement.

Parent/Guardian Signature____**Date:**______________________________

Print Name:____