Saratoga Central Catholic MS/HS
247 Broadway, Saratoga Springs, NY 12866

EMERGENCY CONTACT/INFORMATION AUTHORIZATION FORM

(please print clearly, fill out both sides)

Student's Name _____ Home Phone _____

Address _____

Grade _____ Date of Birth _____

Father's Name _____ cell # _____

Place of Employment _____ work # _____

Mother's Name _____ cell # _____

Place of Employment _____ work # _____

Brothers & Sisters	**Grade**

Emergency Contact Person(s) & Relationship:

Name _____ Address _____

Phone # _____ Relationship _____

Name _____ Address _____

Phone # _____ Relationship _____

If none of the above can be reached, I will allow my child to be transported to the Emergency Room by ambulance for medical treatment as necessary. I realize that SCC and the Albany Diocese cannot assume responsibility for the payment of any medical fees incurred.

******My child has the following medical condition which requires these steps to be followed in case of an emergency****:**

_____

_____

Pediatrician's Name _____ Pediatrician's Phone _____

Pediatrician's Fax _____

EMERGENCY CLOSING:

We need you to complete a plan of action for your child in the event of an emergency closing.

This plan should detail your child's supervision from the time of dismissal. this information must be accurate and updated as needed. It should not require the school to call. We may be unable to hold your child at school until the end of the regular school day.

In the event of an emergency closing, my child should do the following:_____

_____

_____

_____

_____ _____

Parent Signature Date

Transportation to/from school - Bus(which school District)_____

Parents Transport_____

SCC Bus _____

Drive Themselves_____