



EMERGENCY INFORMATION FORM - REQUIRED

Please complete the requested information below and return the original signed form to the school office for our files. The school office must receive a separate copy for each student.

Student Full Name: _____ **Grade:** _____

Student Birth Date: _____

I, the parent or legal guardian of the student listed above, do hereby release Trinity Lutheran Church and School and the Northern Illinois District of the Lutheran Church, Missouri Synod and any and all adult supervisors, or school staff in the event of any accident, enroute, during and returning from any Trinity sponsored event.

Medical Authorization

In my absence, I authorize one of the staff or adult leaders of Trinity Lutheran Church and School to act on my behalf and approve appropriate emergency medical treatment for my child.

Allergies: _____

Allergies Notes: _____

Medical Conditions: _____

Medical Notes: _____

Does this student have medication on file in the school office? **Yes** **No**

Doctor's Name: _____ Phone: _____

Insurance Company: _____

Insurance Policy: _____

In Case of Emergency or Illness, please contact:

1st CONTACT:

Name: _____ Relation to Student: _____

Home: _____ Cell: _____ Business: _____

2ND CONTACT:

Name: _____ Relation to Student: _____

Home: _____ Cell: _____ Business: _____

Signature of Parent or Guardian

Date