



St. Peter's Lutheran School

Student Emergency File 2018-2019

Name of Child: _____

Address: _____

Email: _____ Date of Birth: _____

Family Code Word: (if you use one) _____

Name of Parent or Guardian: _____ Cell # _____

Name of Parent or Guardian: _____ Cell# _____

In Case of Emergency and we cannot reach the parent or guardian we may contact:

Person's Name	Relationship	Cell#	Other#

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Physician's Name, Phone & Address:

Physician's Name	Phone #

Address _____

Dentist's Name, Phone & Address:

Dentist's Name	Phone #

Address _____

Should your child suffer from a serious injury and needs to be transported by Emergency Medical Personnel to the nearest hospital, do you give your permission for such transport and agree to pay for the expenses incurred?
 Yes No If No, please explain: _____

Known allergies, asthma, diabetes, epilepsy etc. or special medical condition:

Insurance Information: _____

A DHEC form 2740 SC Certificate of immunization is required **BEFORE** your child begins school. This can be obtained by contacting your pediatrician.

I certify that to the best of my knowledge _____ is in good mental and physical health and able to participate in St. Peter's Lutheran School's program.

Parent/Guardian: _____ Date: _____