



Notre Dame Academy
 4345 Del Mar Trails Road
 San Diego CA 92130
 (858) 509-2300

**EXTENDED DAYCARE
 EMERGENCY FORM**

FAMILY NAME: _____

CHILDREN:

Name: _____	Grade: _____	Name: _____	Grade: _____
Name: _____	Grade: _____	Name: _____	Grade: _____
Name: _____	Grade: _____	Name: _____	Grade: _____
Home Address: _____		_____	_____
	<i>Street</i>	<i>City</i>	<i>State</i> <i>Zip</i>

IN CASE OF ACCIDENT OR EMERGENCY, please notify:

Name of Father: _____	Cell: () _____	Work: () _____
Guardian: _____	Cell: () _____	Work: () _____
Name of Mother: _____	Cell: () _____	Work: () _____
Guardian: _____	Cell: () _____	Work: () _____
Email: _____		

If we cannot be reached, we wish the following person/s to be notified. We authorize each of them to act in our absence and to pick up our children as necessary. They have agreed to comply with the rules of the school.

<u>Name</u>	<u>Relationship</u>	<u>Telephone</u>
(1) _____	_____	_____
(2) _____	_____	_____
(3) _____	_____	_____

Please provide the medical information requested below
 with specific instructions regarding allergies or health conditions for your child.

PARENTS ARE RESPONSIBLE FOR PAYMENT OF TREATMENT NOT COVERED BY SCHOOL INSURANCE.

Family physician: _____ Tel: () _____
 Other physician of choice: _____ Tel: () _____
 Hospital _____
 Allergies: _____

Health Problems/Concerns: _____

Eye Glasses: ___ YES ___ NO Contact Lenses: ___ YES ___ NO

Please inform the School Office of any changes that occur during the School Year.

IN THE EVENT OF A MEDICAL EMERGENCY I (WE) CONSENT TO THE DECISION MADE BY THE SCHOOL AND ITS AGENTS RELATING TO THE PROVISION OF MEDICAL ASSISTANCE.

Signature of Parent / Guardian: _____ Date: _____
 Relationship to the Student: _____