

**Washington Jesuit Academy
EMERGENCY INFORMATION FORM
2019-2020**

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: _____

Additional Emergency Contact (must complete):

Name: _____ **Relationship to Student:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Student's Physician's Name: _____ **Phone:** _____

Medical Information

Food allergies/sensitivities: _____

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: _____