

Grade (2026-27): **EMERGENCY CONTACT FORM 2026-2027 SCHOOL YEAR**

Student's Name: _____ DOB: ____/____/____
First Middle Last

Present Address: _____ Phone: (____) _____ - _____

City: _____ State: _____ Zip Code: _____

Email: _____

My child may require the use of:

Epi-Pen

Inhaler

Other: _____

Father/Guardian's Name: _____	Mother/Guardian's Name: _____
Address: _____	Address: _____
City: _____ State: ____ Zip: _____	City: _____ State: ____ Zip: _____
Home Phone: (____) _____ - _____	Home Phone: (____) _____ - _____
Cell Phone:(____) _____ - _____	Cell Phone:(____) _____ - _____
Email Address: _____	Email Address: _____
Occupation:	Occupation:
Employer: _____	Employer: _____
Business Phone: (____) _____ - _____	Business Phone: (____) _____ - _____

School Emergency Authorization Form

I hereby authorize Rock County Christian School to call an ambulance in case of accident or acute illness, and to arrange for necessary emergency medical and surgical care, in case I am not immediately available. Any qualified medical professional called by Rock County Christian School may treat and perform whatever medical procedure is necessary for the health and well being of my child.

It is understood that a conscientious effort must be made to notify parents/guardians before such action will be taken.

I hereby consent to have my child participate in field trips and activities supervised by the staff - away from the school grounds.

Your signature grants permission for the additional contacts listed below to remove your child from school if needed for illness or injury. You may also give permission on the day of the incident for others to remove your child.

#1 Primary Contact:			
(other than parent) Name	Home Phone	Work Phone	Relationship to child
_____	_____	_____	_____
#2 Alternate Contact:			
(other than parent) Name	Home Phone	Work Phone	Relationship to child
_____	_____	_____	_____
Parent/Guardian Signature		Date	
_____		_____	

Medication: I hereby authorize Rock County Christian School to administer the following non-prescription medication to my child as needed and not to exceed the recommended dosage according to instructions: As a parent or guardian, I understand that I must provide the appropriate unexpired medication in its original packaging

- Ibuprofen (i.e. Advil) Acetaminophen (i.e. Tylenol) Cough Drops Antacid (i.e. Tums) Other: _____

Allergies: Rock County Christian School needs to be aware of the following items that my child is allergic to:

FOOD _____

OTHER ALLERGIES: _____

Parent/Guardian Signature: _____ Date: _____

In case of medical emergency 911 will be called

