Our Lady of Mt. Carmel School

The following information is required for each STUDENT.

Last Name :	First Name :	Grade :

Address :	City :	State :	Zip :

Allergic To:	______________________________ ______________________________
Medical Conditions:	______________________________ ______________________________

Father's Information

Name ______________________________

Home Phone ☐ ______________________________

Business Phone ☐ ______________________________

Cell Phone ☐ ______________________________

Mother's Information

Name ______________________________

Home Phone ☐ ______________________________

Business Phone ☐ ______________________________

Cell Phone ☐ ______________________________

Family Physician: ______________________________ ***Phone***: ________________

Emergency Contacts

Please provide numbers of at least 2 people we can reach during the day if you are not available.

Name	*Relationship*	*Home Phone*	*Cell Phone*	*Business Phone*

Special Dismissal Restrictions ***i.e. My child should not be released to:***

IF NECESSARY: Emergency Transport to Westchester County Medical Center only

Additional forms are available on our website if any information changes throughout the school year.

10/29/13: wpdocs\medical\Contact Form 2013