

Romar Academy Emergency Data Sheet

Child's Name _____ Last _____ First _____ DOB _____ Grade Level _____ Sex: M / F

I elect to make my information available to other Romar parents as needed.

I elect to keep my information private for official use only.

Notifications regarding announcements and events at Romar should be sent to the following email:

_____ @ _____

Communications from Romar using SMS / text messaging should be sent to the following phones:

Phone 1: () _____ - _____ Phone 2: () _____ - _____ Phone 3: () _____ - _____

Section I - Parent(s) Information

DUE TO STATE LICENSING REQUIREMENTS, IT IS IMPERATIVE THAT EACH ITEM IS COMPLETED. IF AN ITEM DOES NOT APPLY TO YOUR CHILD/FAMILY, PLEASE COMPLETE AS NONE!

Mother's Name _____ First _____ Middle _____ Maiden _____ Last _____

Home Address _____ First _____ Middle _____ Maiden _____ Last _____

City _____ **School District** _____ State _____ Zip _____

(Atlanta Public Schools, Fulton Co., Marietta City Schools, etc)

Work Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell/Pager (_____) _____ Email Address _____ @ _____

Father's Name _____ First _____ Middle _____ Last _____

Home Address _____ First _____ Middle _____ Last _____

City _____ **School District** _____ State _____ Zip _____

(Atlanta Public Schools, Fulton Co., Marietta City Schools, etc)

Work Address _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____

Cell/Pager (_____) _____ Email Address _____ @ _____

ICE (In Case of Emergency Please Contact) In case of emergency this contact will be used first!

Name: _____ () _____ -- _____ Relationship: _____

Section II - Authorized Pick-Ups & Emergency Contacts

(PARENTS MUST PROVIDE THREE EMERGENCY CONTACTS WITHIN THE METRO ATLANTA AREA!)

1. _____
First & Last Name _____ Relationship _____ Home Phone _____

_____ Current Address (Street/City/State/Zip) _____ Cell Phone _____ Other Phone _____

2. _____
First & Last Name _____ Relationship _____ Home Phone _____

_____ Current Address (Street/City/State/Zip) _____ Cell Phone _____ Other Phone _____

3. _____
First & Last Name _____ Relationship _____ Home Phone _____

_____ Current Address (Street/City/State/Zip) _____ Cell Phone _____ Other Phone _____

AS LEGAL GUARDIAN, I DECLARE THE ABOVE LISTED INFORMATION IS ACCURATE AND I MAINTAIN FULL RESPONSIBILITY FOR UPDATING THIS FORM UPON ANY CHANGES TO CONTACT INFORMATION. I ALSO UNDERSTAND ROMAR ACADEMY REMAINS NEUTRAL IN ALL CUSTODY MATTERS AND PROOF OF CUSTODY, AS WELL AS ITS PARAMETERS / RESTRICTIONS, MUST BE RECEIVED IN THE FORM OF AN AFFIDAVIT SIGNED BY A JUDGE.

Parent Signature

Date

Section III – Student Medical Information

In case of an emergency at Romar Academy, the student will be transported to South Fulton Medical Center (**South Fulton Medical Center, 1170 Cleveland Avenue, East Point, GA, 30344, 404-466-1170**) with this sheet. If on a field trip, the student will be transported to the nearest emergency room listed on the field trip permission form and this sheet will be faxed to the emergency care facility.

Do not leave any field blank as it can cause a delay in the proper medical treatment for your child!

Child's Physician _____ Phone _____

Address _____

City/State/Zip _____

Child's Primary Healthcare: _____ Account #: _____

Medical Facility the center uses: **South Fulton Medical Center 1170 Cleveland Avenue East Point, GA 30344**

Child's Food Restrictions: _____

Reason: Religious

Parental Discretion

A COMPLETED ALLERGY ACTION PLAN IS REQUIRED FOR ANY FOOD OR OTHER ALLERGIES!

Child's Food Allergies: _____

Please list any health conditions such as asthma, allergy to bee stings or other allergies, seizures, etc., which Romar should be aware: _____

Current Prescribed Medication: _____

Child is Allergic to the following medications: _____

Child's Special Medical Needs and/or Conditions: _____

In keeping with Romar's non-sectarian commitment to families, please list any religious preferences for medical treatment: _____

IN THE EVENT OF AN EMERGENCY INVOLVING MY CHILD, AND IF ROMAR ACADEMY DOES NOT REACH ME, I HEREBY AUTHORIZE ANY NEEDED EMERGENCY MEDICAL CARE. I FURTHER AGREE TO BE FULLY RESPONSIBLE FOR ALL MEDICAL EXPENSES INCURRED DURING THE TREATMENT OF MY CHILD.

Parent Signature

Date