



St. Joan of Arc School

SHADOW DAY EMERGENCY FORM

Paula Jenkins
Principal

This form must be completed by the parent/guardian in case of an accident or medical emergency and must be received by the school at least **one week prior** to the Shadow Day.

Student Information

Name _____ Shadow Date _____

Address _____ Home Phone # _____

City _____ State _____ Zip Code _____

Current School _____ Current Grade _____

Mother's Name _____

Mother's Work # _____ Mother's Cell # _____

Father's Name _____

Father's Work # _____ Father's Cell # _____

Please list any allergies to food, medicine, or any other pertinent health information:

Emergency Contact Information

Please provide two emergency contacts (e.g.: relative, neighbor) in case you cannot be reached.

#1 Contact _____ Telephone # (____) _____

Relationship _____

#2 Contact _____ Telephone # (____) _____

Relationship _____

In case of an emergency, when I cannot be reached by phone, I hereby grant school authorities permission to take my child (name) _____ to any licensed physician, dentist, eye doctor, or hospital. In case of severe bleeding, poisoning, or where artificial respiration is necessary, I give the school permission to take immediate action as necessary.

Signature of Parent/Guardian

Date

587 Grattan Street Chicopee, MA 01020
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Founded in 1885