



SAINT NICHOLAS GREEK ORTHODOX CHURCH

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ST. NICHOLAS GREEK ORTHODOX CHURCH YOUTH PROGRAMS Parental instructions in case of emergency School Year _____

Student _____ Birth date _____

Address _____ City _____ Zip _____

Please list everyone we can call in case of an emergency or school closing:

Note: if a parent/guardian is not available, we will call the next person on the list until someone is contacted.

1.	_____	_____	_____	_____	_____
	Name	Parent/Guardian	Work	Home	Cell/Pager
2.	_____	_____	_____	_____	_____
	Name	Parent/Guardian	Work	Home	Cell/Pager
3.	_____	_____	_____	_____	_____
	Name	Parent/Guardian	Work	Home	Cell/Pager
4.	_____	_____	_____	_____	_____
	Name	Parent/Guardian	Work	Home	Cell/Pager

OVER for medical information and signature

MEDICAL INFORMATION

This information will be shared with appropriate school staff.

If the designated parties are not available, I understand appropriate emergency care deemed advisable by St. Nicholas school authorities or St. Nicholas youth advisors will be sought. Any special decisions appropriate to my child have been checked.

Doctor's Name _____ Phone Number _____

Dentist's Name _____ Phone Number _____

Hospital _____ Phone Number _____

Emergency Clinic _____ Phone Number _____

Please put an "X" in the appropriate box, specify where indicated, and sign your name.

- | | |
|---|---|
| <input type="checkbox"/> 1. Religious objections to physician contact | <input type="checkbox"/> 10. Life threatening allergies (reaction): |
| <input type="checkbox"/> 2. Contact lens/glasses | med/drug _____ |
| <input type="checkbox"/> 3. Bone/joint condition | food _____ |
| <input type="checkbox"/> 4. Diabetes | insect _____ |
| <input type="checkbox"/> 5. Heart condition _____ | <input type="checkbox"/> 11. Medications needed or used: _____ |
| <input type="checkbox"/> 6. Seizure disorder _____ | _____ |
| <input type="checkbox"/> 7. Hypertension or high blood pressure | <input type="checkbox"/> 12. Other conditions or problems: _____ |
| <input type="checkbox"/> 8. Asthma _____ | _____ |
| <input type="checkbox"/> 9. Special blood condition: _____ | <input type="checkbox"/> 13. None known. |

Date _____ Signature _____
 (Parent or Guardian)