

**St. Andrew Catholic School 1509 S. E. 27th St.  
Cape Coral, FL 33904**

**2023-2024 AUTHORIZED PICK-UP LIST**

**PLEASE PRINT**

Student's Name: \_\_\_\_\_ Grade/Teacher: \_\_\_\_\_

Only those indicated below and anyone else designated by a parent/guardian in writing will be permitted to pick up your child.

For your child's protection, please fill out the name of authorized persons to bring or take your child from the school, other than yourself. Please inform the authorized persons to be prepared to identify themselves to our staff. **Please list parent other than one signing this, if authorized to pick up.**

Authorized Person's Name	Relationship To Child	Authorized Person's Name	Relationship To Child
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

If someone other than the persons named above will pick up, please contact the school and teacher with that information. Early dismissals must be  
If you wish to add someone *permanently* to the above list, please contact the school: 239-772-3922.  
In case of a car pool arrangement, designate such on the line "Relationship", or tell us here what the arrangements will be:

\_\_\_\_\_  
\_\_\_\_\_

**We release child(ren) to either parent unless we have a court order regarding custody. Please attach.**

Is there anyone who might stop for your child to whom you do **NOT** wish your child released?

\_\_\_\_\_

**Please refer to the on-line Parent/Student Handbook for information regarding students walking or riding their bikes to school.**

**In the event of an emergency (national/weather/personal) where none of the listed people are able to pick up your child, please establish a family "password" which will be given to us by the person coming for your child as proof of authorization to do so.**

Family Password for Emergencies: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Please complete one form per student; return by Aug. 9**  
**(Pls. return as 2-sided)**

**Emergency Medical Authorization -- OVER --**

**PLEASE COMPLETE ONE FORM FOR EACH STUDENT; RETURN TO SCHOOL BY AUGUST 9.**

**SAINT ANDREW CATHOLIC SCHOOL**

**PLEASE PRINT CLEARLY**    **2023-2024 EMERGENCY MEDICAL AUTHORIZATION**    DATE: \_\_\_\_\_

Student's Name: \_\_\_\_\_ Birth (M/D/Y) \_\_\_\_\_ Phone: \_\_\_\_\_

Parent/FamilyName(s): \_\_\_\_\_

Address: \_\_\_\_\_ Email: \_\_\_\_\_

In case of emergency/illness, please list **four people (INCLUDING YOURSELF)** the order in which we **should contact** for assistance in the care of your child:

Name	Relationship	Work #	Cell #
1) _____	_____	_____	_____
2) _____	_____	_____	_____
3) _____	_____	_____	_____
4) _____	_____	_____	_____

**MEDICAL INFORMATION:** Please list all information pertaining to allergies, dietary needs, special medication, physical impairments, blood type, health conditions or any other information necessary in an emergency situation. Explain fully:

Child's Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

In case of illness or injury of the above student, reasonable effort will be made to contact the Parent(s)/legal guardian(s)/emergency contact. In case of a medical emergency when these parties cannot be notified or are not available, I (we) authorize parish or diocesan officials to consent to any x-ray examination, anesthetic, medical or surgical treatment, and/or hospital care, as determined to be necessary and appropriate by a physician licensed in the state in which treatment is sought. This authorization is valid for a period of 2 years from the date of execution. I (We) agree to assume financial responsibility for any medical treatment provided to the youth.

\_\_\_\_\_  
Signature of Parent or Legal Guardian

**Return completed as 2-sided, please.**