

Emergency Medical Authorization

You must complete a new form each year for each child

Please Print

Student Name _____ Date of Birth _____

Address _____

City/State _____ Zip _____

Home Phone _____ Cell Phone _____ / _____ E-mail _____
Mother Father

Mother's Name _____

Employed at _____ Daytime phone _____

Father's Name _____

Employed at _____ Daytime phone _____

IF ABOVE NAMED PARENTS OR GUARDIANS CANNOT BE REACHED, PLEASE CALL:

First Contact Name _____ Relationship _____

Home phone _____ Work phone _____ Cell phone _____

Second Contact Name _____ Relationship _____

Home phone _____ Work phone _____ Cell phone _____

In case of accident or serious illness, I request the parish representative to contact me or my designate. If this cannot be done, I authorize the parish to call the physician or dentist listed on this form and to follow his/her instructions. If the physician or dentist named cannot be reached, the parish may seek medical services that seem necessary. I realize the parish or its representative does not assume responsibility for the payment of medical expenses.

In the event emergency treatment is needed, I give the hospital, its authorized personnel and/or physician permission to treat my son/daughter as necessary.

Signature _____ Date _____

Allergies (food or medical) _____

Medical problems _____

Taking medications? Yes _____ No _____ If yes, please list: _____

Physician _____ Phone _____

Dentist _____ Phone _____

Hospital preference _____

Insurance Co. _____ Policy Number _____

OR

I DO NOT GIVE MY CONSENT FOR EMERGENCY MEDICAL TREATMENT OF MY CHILD. In the event of illness or injury requiring medical treatment, I wish the parish and its representatives to take NO ACTION.

Signature _____ Date _____

Please list any information that you feel is necessary for us to know in regards to your child's well being:

