

Grade _____

EMERGENCY MEDICAL AUTHORIZATION (Please Print)

Student's Name _____ S.S# _____ Date of Birth _____

Address: _____ Home Phone: _____ Cell Phone: _____

Mother's or Guardian's Name _____ Telephone _____

Where Employed _____ Telephone _____

Father's or Guardian's Name _____ Telephone _____

Where Employed _____ Telephone _____

IF ABOVE PARENTS/GUARDIANS CANNOT BE REACHED, PLEASE CALL:

First Contact's Name _____ Relationship _____

Address _____ Home _____ Work _____

Second Contact's Name _____ Relationship _____

Address _____ Home _____ Work _____

In case of accident or serious illness, I request the Parish to contact me or my designate. If this cannot be done, I authorize the Parish to call the physician or dentist listed on this card 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 does not assume responsibility for the payment of any medical expenses that may incur.

Signature of Parent or Guardian _____ Date _____

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

Signed _____ Date _____

Medical Problems _____

Taking Medications Yes ___ No ___ If yes, type and reason _____

Allergies _____

Physician/Clinic _____ Phone _____

Dentist _____ Phone _____

Hospital Preference _____ Phone _____

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 authorities to take no action or to: _____

Signature of Parent or Guardian _____ Date _____