

**EMERGENCY MEDICAL AUTHORIZATION (please print)**

Students Name: \_\_\_\_\_ Birth date: \_\_\_\_\_ RE Grade \_\_\_\_\_  
Student's Address: \_\_\_\_\_  
\_\_\_\_\_

Mother's/Guardian's Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_  
Father's/Guardian's Name: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

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

Contact's Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell phone: \_\_\_\_\_

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 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 does not assume responsibility for the payment of medical expenses.

Signature of Parent/Guardian \_\_\_\_\_ Date: \_\_\_\_\_

Allergic reactions (medications, foods, insects, etc) \_\_\_\_\_

(Medication(s) currently being taken and reason) \_\_\_\_\_

My child has special medical/mental conditions: Yes \_\_\_ No \_\_\_ (if yes, please describe)

Physician/Clinic \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_  
Hospital preference: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

- 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

**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 with the parish authorities to take no action or to:

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

Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_