

Emergency Medical Authorization (Please print)

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Parish \_\_\_\_\_

Mother's or Guardian's Name

Where Employed \_\_\_\_\_ Telephone \_\_\_\_\_ Ext. \_\_\_\_\_

Father's or Guardian's Name

Where Employed \_\_\_\_\_ Telephone \_\_\_\_\_ Ext. \_\_\_\_\_

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

(A) First Contact's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Work phone # \_\_\_\_\_ Home phone # \_\_\_\_\_

(B) Second Contact's Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Work phone # \_\_\_\_\_ Home phone # \_\_\_\_\_

In case of accident or serious illness, I request the school to contact me or my designate. If this cannot be done, I authorize the school 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 school may seek medical services that seem necessary. I realize the school does not assume responsibility for the payment of medical expenses.

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 son/daughter as necessary.

Signed \_\_\_\_\_ Date \_\_\_\_\_

Allergies \_\_\_\_\_

Medical \_\_\_\_\_ problems  
Taking Medication Yes \_\_\_ No

If yes, Type \_\_\_\_\_ Reason \_\_\_\_\_  
(Medication will be administered at school only according to current school policies.)

Physician/clinic \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ 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 school authorities to take no action or to:

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

Date \_\_\_\_\_