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

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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