Emergency Medical Authorization Form

Student's Last Name **First** **Middle** **Grade for 2019-2020** 2/ **$30 Registration fee Cash ____ Date _____Check # _____**

Address _____ Home Phone _____
Zip Code

E-mail address: _____

Mother's/ Guardian's Name: _____ Work Phone _____

Where employed _____

Father's/ Guardian's Name: _____ Work Phone _____

Where employed _____

List date(s) that your daughter/son cannot attend CYE class(es): _____

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

First Contact's Name _____ Home Phone _____ Work Phone _____

Address _____ Relationship _____

Second Contact's Name _____ Home Phone _____ Work Phone _____

Address _____ Relationship _____

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 medical expenses.

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

Signed: _____ **Date:** _____

Allergies (including foods): _____

Medical Problems: _____

Taking medication: Yes _____ No _____ if yes, type: _____

Reason: _____

Hospital preference: _____

Physician/clinic: _____ Phone: _____

Dentist: _____ 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/Guardian: _____ Date: _____