STUDENT EMERGENCY MEDICAL AUTHORIZATION
Church of the Assumption School

Please Print or Type:

Student's Name _________________________ Birth Date__________ Phone____________________
Address _______________________________ Grade _____________ Room____________________
Student's Social Security Number ____

WHERE PARENT CAN BE REACED IF NOT AT HOME:
FATHER'S NAME_________________ WORK PLACE____________
WORK PHONE_______________

MOTHER'S NAME________________ WORK PLACE____________ WORK PHONE________

IMPORTANT TO LIST TWO NEIGHBORS OR NEARBY RELATIVES WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD/CHILDREN IF YOU CANNOT BE REACHED:

Name______________________ Relationship_____________________ Phone____________________
Name______________________ Relationship_____________________ Phone____________________
Local Physicians Name _______________________________________ Phone____________________
Hospital of Choice ____ Phone____________________

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING CONDITIONS?
Diabetes_______ Asthma________ Epilepsy________ Bleeding_______ Heart Condition ________
Allergic to Drugs? (Specify) ____
Other Unusual Conditions ____

GRANT CONSENT: In case of accident or serious illness, I request the school to contact me. If the school is unable to reach me, I hereby authorize the school to call the physician indicated above and to follow his instructions. If it is impossible to contact the physician, the school may make whatever arrangements seem necessary.

____ __________________________________
SIGNATURE OF PARENT OR GUARDIAN DATE

REFUSAL TO CONSENT: I do not give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to:

SIGNATURE OF PARENT OR GUARDIAN DATE

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