2020–2021 Emergency Medical Authorization (*Please Print clearly*)

Student's Name_____ 2020-2021 Grade_____ Birthdate_____

Address_____ Male ___ Female ___ Home Phone_____

Student's Allergic Reactions: (medications, food, insects, etc.)_____

_____

Student's Current Prescription Medications: (name, dosage, frequency – (If more space needed use reverse side of form)

_____

_____

Student's Medical/Psychological/Etc. Conditions: No__ Yes__ (Please describe on reverse side of form)

Physician: _____ Dentist:_____

Phone:_____ Phone:_____

EMERGENCY CONTACT INFORMATION

Mother's or Guardian's Name_____ Cell Phone_____

Father's or Guardian's Name _____ Cell Phone_____

NAME OF LOCAL CONTACTS IF PARENT(S) OR GUARDIAN(S) ARE NOT AVAILABLE

Primary Contact's Name_____ Relationship_____

Address _____ Cell Phone_____Home_____

Secondary Contact's Name_____ Relationship_____

Address _____ Cell Phone_____Home_____

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

Signature of Parent or Guardian_____Date_____

If my child needs emergency treatment, I give the hospital its authorized personnel and/or physician permission to treat my son/daughter as necessary.

Signature of Parent or Guardian_____Date_____

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 Religious Education office authorities to take no action or to:_____

_____

_____

Signature of Parent or Guardian_____Date_____