

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

This information will be kept in the possession of the school and distributed to the person in charge of each and every trip on which my child participates, or athletic activity. Should the need arise, this information will be given to the proper medical authorities.

I, _____ understand that in the case of illness of my
(Parent's name)
child, _____, St. Malachy School will try to notify me or
(name of child)
the person I have listed below as an emergency contact.

In the case of a medical emergency concerning my child, at a time when I or my listed emergency contact cannot be notified, I grant full power to the school supervising employee to do as follows:

1. Arrange for the transportation of my child, whether by ambulance or otherwise, to a proper facility where emergency medical treatment would normally be administered, including but not limited to, an emergency room of a hospital, a doctor's office, or a medical clinic; and
2. Sign releases as may be required in order to obtain any medical or surgical treatment as is required in the judgment of medical authorities at the facility.

Date: _____

Parent/Guardian Signature

MEDICAL INFORMATION

STUDENT

Name (first, middle, last): _____

Address: _____

EMERGENCY CONTACTS

Parent(s) or guardian

Name (first, middle, last): _____

Phone (including area code): _____

Other contact

Name (first, middle, last): _____

Relationship: _____

Phone (including area code): _____

EMERGENCY RELEASE

These people may pick my child up from school in the case of an emergency situation when the parent or guardian cannot be reached. (Example: school evacuation because of natural disaster)

Name (first, last) _____

Phone (including area code) _____

MEDICAL CONDITIONS

Please list any medical conditions of the above student (asthma, diabetes, epilepsy, etc):

Please list any allergies or allergic reactions to medications of the above student:

Please list any medications the above student is now taking:

Date of student's most recent tetanus shot:

Other pertinent medical information:

MEDICAL INFORMATION

Company: _____

Identification number of plan: _____

Identification number of covered employee: _____
