EMERGENCY CONTACT & MEDICAL INFORMATION

Child's name: _____ Date of Birth: _____

Parent's name (s) : _____

Contact phone # during Religious Education hours: _____/ _____

Medical/Special needs information:

Allergies: _____

Medicines: _____

Chronic Condition/Disability: _____

Learning Challenge / Disability: _____

EMERGENCY INFORMATION:

In case of emergency, if parents/legal guardian cannot be reached, contact:

Name: _____ Relationship: _____

Phone: _____

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

If you and the physician of your choice as indicated above, cannot be reached in an emergency, and, if in the judgment of the Rel Ed coordinator immediate medical and/or hospital attention is indicated, do you authorize the coordinator to send your child (properly accompanied) to an available hospital or physician?

_____***Yes*** _____ ***No*** _____

Parent's signature required *Date*

As a parent and/or legal guardian, I authorize the treatment of my minor child/children by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause physical disability, or cause undue discomfort if delayed. I agree to assume the financial responsibility for any diagnosis, treatment, and/or medication deemed necessary. This consent is granted only after reasonable effort has been made to reach me.

Parent's signature *Date*