

2010-2011
SETON CATHOLIC SCHOOL
AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

This information will be kept in the possession of the school and used in the event of an emergency. Should the need arise, this information will be given to the proper medical authorities.

I, _____ (name of parent/guardian), understand that in the case of illness of my child, _____ (name), _____ (name of school) will try to notify me or the person I have listed below as an emergency contact.

In 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

Parent/Guardian Signature

MEDICAL INFORMATION

STUDENT

Name (first, middle, last): _____
Address: _____
Home Phone: _____

Parent(s) or Legal Guardian(s):

Mother's name (first, middle, last): _____
Address (if different than student): _____

Place of employment: _____
Phone (include area code): WORK: _____
HOME: _____
CELL: _____

Father's name (first, middle, last): _____
Address (if different than student): _____
Place of employment: _____
Phone (include area code): WORK: _____
HOME: _____
CELL: _____

PLEASE COMPLETE BACK OF FORM ALSO

**ADDITIONAL EMERGENCY CONTACTS:
(EVERY STUDENT IS REQUIRED TO HAVE TWO)**

Name (first, middle, last): _____

Phone (**where they can be reached during school hours**) area code: _____ - _____

Relationship: _____

Name (first, middle, last): _____

Phone (**where they can be reached during school hours**) area code: _____ - _____

Relationship: _____

STUDENT'S REGULAR PHYSICIAN: _____

Phone: _____

MEDICAL CONDITIONS

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

Please list any allergies and/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: _____

