

**St. Anthony of Padua School
EMERGENCY MEDICAL FORM**

STUDENT NAME _____ DOB _____

MEDICAL

Doctor's Name _____ Phone _____

Dentist's Name _____ Phone _____

Health Policy No. _____ Preferred Hospital _____

Allergies _____ Life Threatening? _____ (Y/N)

Other _____

Health Factors _____

PARENT CONTACT INFORMATION	
Last Name _____	
First Name _____	
Relationship _____	
Language _____	
Address _____	<div style="border: 1px solid black; width: 100%; height: 60px;"></div>
Home Phone No. _____	
Email Address _____	
Work Place _____	
Work Phone _____ Ext. _____	
Cellular Phone _____	

PARENT CONTACT INFORMATION	
Last Name _____	
First Name _____	
Relationship _____	
Language _____	
Address _____	<div style="border: 1px solid black; width: 100%; height: 60px;"></div>
Home Phone No. _____	
Email Address _____	
Work Place _____	
Work Phone _____ Ext. _____	
Cellular Phone _____	

My child may be released to:	
Last Name _____	
First Name _____	
Relationship _____	
Language _____	
Address _____	<div style="border: 1px solid black; width: 100%; height: 60px;"></div>
Home Phone No. _____	
Email Address _____	
Work Place _____	
Work Phone _____ Ext. _____	
Cellular Phone _____	

Add Additional
Release
Contact
Information
on the back

My child my be released to:	
Last Name _____	
First Name _____	
Relationship _____	
Language _____	
Address _____	<div style="border: 1px solid black; width: 100%; height: 60px;"></div>
Home Phone No. _____	
Email Address _____	
Work Place _____	
Work Phone _____ Ext. _____	
Cellular Phone _____	

MEMO

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctor, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Parent(s) Signature _____ Date _____

REFUSAL TO CONSENT: I do not give my consent for emergency medical treatment of my child. In the event of injury requiring emergency treatment, I wish the school authorities to take the following action: _____

Parent(s) Signature _____ Date _____