

St. Anthony of Padua Parish School

2018 - 2019 LATCHKEY 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 _____

Phone _____

Email Address _____

Work Phone _____ Ext. _____

PARENT CONTACT INFORMATION

Last Name _____

First Name _____

Relationship _____

Phone _____

Email Address _____

Work Phone _____ Ext. _____

My child may be released to:

Last Name _____

First Name _____

Relationship _____

Phone _____

My child may be released to:

Last Name _____

First Name _____

Relationship _____

Phone _____

My child may be released to:

Last Name _____

First Name _____

Relationship _____

Phone _____

My child may be released to:

Last Name _____

First Name _____

Relationship _____

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 _____