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

Home Phone No. _____
Email Address _____
Work Place _____
Work Phone _____ Ext. _____
Cellular Phone _____

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MEMO

In the event reasonable attempts to contact me have been unsuccessul, 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*_____