NOTRE DAME
NDCL
CATHEDRAL LATIN

Emergency Medical Form

Student's Name: _____ Home Telephone (_____) _____
Last Name First Name M.I.

Address: _____ City _____ Zip _____ Birth Date _____

RESIDENTIAL PARENT OR GUARDIAN:

MOTHER: _____ Employer: _____

Work Phone: (_____) _____ Cell Phone: (_____) _____ Pager: (____) _____

FATHER: _____ Employer: _____

Work Phone: (_____) _____ Cell Phone: (_____) _____ Pager: (____) _____

Family E-Mail Address: _____ @ _____

If my child becomes ill at school and you cannot reach me/us at the numbers listed above, you may call and release my child to:

NAME: _____ Relationship to student: _____

Work Phone: (_____) _____ Cell Phone: (_____) _____ Pager: (____) _____

PART I: TO GRANT CONSENT **(If completing this section, do not complete PART II.)**

I hereby give consent for the following medical care providers and local hospital to be called:

Physician: _____ Telephone: (_____) _____

Dentist: _____ Telephone: (_____) _____

Medical Specialist: _____ Telephone: (_____) _____

Local Hospital: _____

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 doctors, 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 (2) other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

_____

_____

Date: _____ Signature of Parent/Guardian: _____

Address : _____ City/State: _____ ZIP: _____

PART II: TO REFUSE CONSENT **(If completing this section, do not complete PART I.)**

I do **NOT** give my consent to emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action(s):

_____

_____

Date: _____ Signature of Parent/Guardian: _____

Address : _____ City/State: _____ ZIP: _____