

HOLY COMMUNION CHURCH

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Last Name (Family) _____

Parent/Guardian _____
Signature _____

Cell Phone _____

Parent/Guardian _____
Signature _____

Cell Phone _____

Home Address _____ Home Phone _____

I (We) the above-named Parent(s)/Guardian(s), certify that the party signing is the parent/guardian of the child(ren) listed below and consent to the administration by a registered nurse, licensed physician, or dentist any necessary emergency treatment to the minor(s)) named below and to the transfer of such minor(s) to any hospital reasonably accessible when medically necessary as reasonably determined by the caregiver. This authorization does not cover major surgery unless an additional licensed physician concurs that such surgery is necessary. This authorization is effective on September 1, 2018 and expires May 30, 2019.

Family Physician _____ Phone _____

Dentist/Orthodontist _____ Phone _____

Do you carry medical/hospital insurance? Yes___ No___ If yes, please indicate:

Insurer _____ Policy/Group# _____

Child's Name _____ Birthday ___/___/___ Sex___ Age_____

Food/Drug Allergies _____

Specific Needs in Regards to Food _____

Operations (what/when) _____

Disability/Chronic Illness _____

Is the child taking medication prescribed by a physician now? Yes___ No___

If so, please list all medications prescribed, the size of dose, and when it is taken.

Child's Name _____ Birthday ___/___/___ Sex___ Age_____

Food/Drug Allergies _____

Specific Needs in Regards to Food _____

Operations (what/when) _____

Disability/Chronic Illness _____

Is the child taking medication prescribed by a physician now? Yes___ No___

If so, please list all medications prescribed, the size of dose, and when it is taken.