HOLY COMMUNION CHURCH

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Last Name (Family) _____

Parent/Guardian_____ Cell Phone_____
Signature_____

Parent/Guardian_____ Cell Phone_____
Signature_____

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.

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Food/Drug Allergies_____

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