Emergency Medical Treatment Authorization/Consent Form

Child's Full Name: _____
Child's Birth Date: _____

This form allows parents and guardians to authorize the provision of emergency treatment for the above named child who becomes ill or injured while under program authority when parents or guardians cannot be reached.

Name of Parent or Legal Guardian: _____
Address: _____
Primary Phone: _____ Work Phone: _____

Name of Parent or Legal Guardian: _____
Address: _____
Primary Phone: _____ Work Phone: _____

Person(s) to contact in case of emergency if parents are unavailable:

Name: _____
Relationship to child: _____
Phone: _____

Name: _____
Relationship to child: _____
Phone: _____

Doctor: _____ Phone: _____
Address: _____

Dentist: _____ Phone: _____
Address: _____

Hospital Preference: _____
Present Medication(s): _____
Known Allergies: _____

Please complete back side

In the event that my child may require emergency treatment, I hereby authorize Holy Cross School officials to secure medical treatment. I authorize Doctor (physician)_____ or Doctor (dentist)_____, or in the event the designated practitioners are not available, then by another licensed physician or dentist to provide this care. I also authorize the center to administer emergency care or treatment as required, until emergency medical assistance arrives. I agree to pay all the costs and fees contingent for any emergency medical care, treatment and/or transportation for my child as secured or authorized under this consent.

This consent will be effective for one year beginning (date)_____

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Signature of Parent or Legal Guardian Date