St. Catharine Preschool Emergency Form

Child's Name ____ DOB ___________ Last 4 # of SS ________

Address ____ Home Phone:__________________

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Parent 1 Name_______________________________________ Cell Phone:__________________________

Address _______________________________________ Email: ______________________________

(if different than above)

Place of Employment __________________________________ Work Phone: _________________________

Parent 2 Name_______________________________________ Email: ______________________________

Address ____ Cell Phone: __________________________

(if different than above)

Employer _______________________________________ Work Phone : ________________________

In the event this student becomes ill at school but does not need medical attention, name two people to be contacted if you cannot be reached.

Name: ____________________________________ Name: ____

Phone Number: ________________________ Phone Number: ______________________________

Relationship to the child: ________________ Relationship to the child: ____________________________

List of Person(s) to whom this child can be released:

Name:	Relationship to the child:
____	____
____	____
____	____
____	____

St. Catharine Preschool Emergency Form

Emergency Medical Authorization

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Part 1 OR Part 2 must be completed

Part 1: To Grant Consent

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

Physician: ____ Phone ____________________________

Dentist: ____ Phone _____________________________

Local Hospital: ____________________________________ Emergency Room Phone _______________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the (1) authorization of any treatment deemed necessary by the 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 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.

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

(Medical History/ Allergies/ Chronic Physical Problems)

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Date: _________________________ Signature of Parent/Guardian ___________________________________

DO NOT COMPLETE PART 2 IF YOU COMPLETED PART 1

Part 2: Refusal to Consent

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

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Date: _________________________ Signature of Parent/Guardian ___________________________________