

St. Catharine Preschool Emergency Form

Child's Name _____ DOB _____ Last 4 # of SS _____

Address _____ Home Phone: _____

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 a parent cannot be reached and a student becomes ill or needs non-emergency medical attention while at school, name two people to be contacted. Include these names on the pickup list below.

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, including parents: (We will release children to these people at any time- if you need a temporary person to pick up but do not want them permanently on the list you can notify us in writing or send an email)

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)

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:

Date: _____ Signature of Parent/Guardian _____