

**Sacred Heart Faith Formation
Emergency Medical Form**

Student's Name _____ Birth date _____

Address _____ Home Phone _____

City _____ Zip _____

Mother's Name _____ Business Phone _____

Employer _____ Address _____

Father's Name _____ Business Phone _____

Employer _____ Address _____

Parents: Married___ Divorced___ Deceased___ Remarried___ Separated___

Child lives with: _____

Family Doctor's Name _____ Phone _____

Insurance's name and number _____

Hospital preference _____

Allergies or Medical Problems or Medicines taken regularly _____

(Please use reverse side to explain further if necessary)

Has your child been diagnosed with a learning disability or attention deficit disorder? _____

Specify: _____

Date of last Tetanus Vaccine _____ Immunization up to date? Y___ N___

Please list the names and phone numbers of three responsible persons we may contact in case of an emergency.

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____

Authorization for Treatment of Minor

I, _____ being the parent or legal guardian of _____

give my consent for emergency medical and surgical treatment of this minor in a licensed hospital by a licensed Indiana physician should his/her conditions so require it in my absence. I understand that in such case reasonable attempts would first be made to contact me, time and conditions permitting.

As long as the medical or surgical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitation or prohibitions regarding treatment other than those that follow. If none, so state, I assume financial responsibility for the same.

Limitations: _____

This authorization is effective for the following period: September 2009 to September 2010

Father's Signature

Mother's Signature