

Student's Last Name First Middle Grade (2020-2021)

Address: _____ Home Phone: _____

Email address: _____ Email address: _____

Mother's/Guardian's Name: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

Father's/Guardian Name: _____ Cell Phone: _____

Employer: _____ Work Phone: _____

**The purpose of this form is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under the parish authority, when parents or guardians cannot be reached.*

Part I: To Grant Consent

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

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Medical Specialist: _____ Phone: _____

Local Hospital: _____ Phone: _____

Allergies: _____

Medical conditions: _____

Taking Medication: _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the parish to call the physician or dentist listed on this card and to follow his/her instructions. If the physician or dentist named cannot be reached, the parish may seek medical services that seem necessary. I realize the parish does not assume responsibility for the payment o medical expenses.

In the event emergency treatment is needed, I give the hospital, its authorized personnel and/or physician permission to treat my daughter/son as necessary.

Signature: _____ Date: _____

Part II: Refusal to Consent

I do NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring medical treatment, I wish the parish authorities to take no action or to:

Signature: _____ Date: _____