

EMERGENCY HEALTH INFORMATION

Student(s) name _____ Grade(s) _____

In the event of an illness or injury, or special circumstances, Queen of All Saints will release your student ONLY to those adults (other than parents) below:

NAME	CELL PHONE	HOME PHONE	RELATIONSHIP
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

In real emergencies call: Dr. _____ Phone _____

Or any physician available Yes ___ No ___

Health Plan Name _____ Number _____

Hospital you use: _____

Special Medical Conditions/Allergies: _____

Medications: _____

Special Learning Challenges Known: _____

Do we have your permission to inform the child's catechist of the above conditions, if any? Yes _____ No _____

I/We authorize an adult, appointed by the Faith Formation Office, in whose care the minor has been entrusted, to consent to any x-ray examination, anesthetic, medical surgical or dental diagnosis or treatment, and hospital care, to be rendered to the minor under the general or special supervision and on the advice of any physician or dentist licensed under the provision of the Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered at the office of said physician or at said hospital. The undersigned shall be liable and agrees to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned minor pursuant to the authorization.

Should it be necessary for our/my child to return home due to medical reasons or otherwise, the undersigned shall assume all transportation costs.

Parent/Guardian Signature _____

Date _____

OFFICE USE ONLY	
Date Reg.:	_____
Amount Paid:	_____
Check #	_____
Cash	_____