Emergency Medical Authorization

2020 – 2021

Child's Name_____

Pediatrician's Name _____ Phone Number_____
Child's present health status (list any problems or concerns)

_____

_____

_____

Are there any foods your child may not eat (due to allergies, etc.) Yes No
If yes, please list:

_____

_____

Person to be called in case of emergency, when parents can NOT be reached.

Name_____ Phone Number_____

In the event of a medical emergency,
I hereby grant permission for Holy Family Day School to obtain emergency medical care for my child.
The following will take place:
1. An attempt will be made to contact a parent or guardian, the child's physician, or the person listed on this form.
2. If none of the above people can be contacted, Holy Family Day School will call 911 and have the child taken to the hospital in the company of the school Director/Staff member.

I understand that the payment of medical care expenses is the responsibility of the parent/guardian.

_____

Parent/Guardian Signature Date