



# EMERGENCY TREATMENT RELEASE FORM

**Parent/Guardian:**

**Your parish has adopted the following procedures in caring for your child when he/she becomes ill or injured at Religious Education classes. In certain cases if extreme emergency, an ambulance may be called immediately.**

**In most cases of emergency and/or need of medical/hospital care:**

- 1. The DRE/Catechist/Youth Minister will call the home.**
- 2. If there is no answer at the home, the DRE/Catechist/Youth Minister will call the place of employment of the mother, father or guardian.**
- 3. If there is no answer at the workplace, the DRE/Catechist/Youth Minister will call the other numbers listed and the physician.**
- 4. If there is no answer at these numbers, the DRE/Catechist/Youth Minister will call the ambulance, if necessary, to transport the child to a local medical facility.**
- 5. The DRE/Catechist/Youth Minister will continue to call the parent, guardian or physician until contact is made.**

**Please sign and complete the following form:**

**If I cannot be reached, I request that the DRE/Catechist/Youth Minister act in the best medical interests of my child and I agree to assume all expenses for moving and medically treating him/her. I also hereby consent to any treatment, surgery, diagnostic procedures or the administration of anesthesia, which may be carried out based on the medical judgment of the attending physician.**

**Signature of Parent/Guardian** \_\_\_\_\_ **Date** \_\_\_\_\_

Student's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Phone: \_\_\_\_\_  
*Last First Middle Mo. Day Year.*

Parish: \_\_\_\_\_ Home Address: \_\_\_\_\_  
*Street City State Zip*

Mother/Guardian's Name: \_\_\_\_\_ Father/Guardian's Name: \_\_\_\_\_

Mother's Place of Employment: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

Father's Place of Employment: \_\_\_\_\_ Daytime Phone: \_\_\_\_\_

If parents/guardian's cannot be reached, notify the following who will provide the transportation if necessary:

<i>Name</i>	<i>Address</i>	<i>Phone</i>	<i>Cell</i>
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<i>Name</i>	<i>Address</i>	<i>Phone</i>	<i>Cell</i>
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Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

Indicate student's serious medical problems: \_\_\_\_\_

Student is allergic to: ( ) Penicillin ( ) Aspirin ( ) Other \_\_\_\_\_

Medical Insurance: \_\_\_\_\_

Company \_\_\_\_\_ ID# \_\_\_\_\_ Group # \_\_\_\_\_

**Please return to your parish.**