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:

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Name Address Phone Cell

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Name Address Phone Cell

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.