# 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:

_____
*Name Address Phone Cell*

_____
*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.**