

Parish School of Religion
Medical Information Form -- 2011-2012

St. Mary's Religious Education Office
265 Baker Street, Berea, Ohio 44017 Telephone: 440-243-8221 Fax: 440-243-8411

MEDICAL INFORMATION:

Student's Name: _____

Purpose: To enable parents/guardians to authorize emergency treatment for children who become ill or injured while under the authority of the Parish School of Religion when parents/guardians cannot be reached.

I give my consent for treatment in the event reasonable attempts to contact me at _____ or other parent/guardian at _____ have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by

(preferred doctor) _____

(preferred doctor phone) _____

or in the event the designated preferred physician is not available, by another licensed physician or dentist; and (2) the transfer of the child to (preferred hospital) _____ or any reasonably accessible hospital.

This authorization does not cover any major surgery unless the medical opinions of (2) other licensed physicians or dentists concur in the necessity for such surgery and concurrence is obtained before the surgery is performed.

Parent/Guardian Signature: _____ Date: _____

I do not give my consent for treatment

In the event of illness or emergency treatment required, I wish the PSR authorities to: _____

Parent/Guardian Signature: _____ Date: _____

Are there any special needs (medications, allergies, asthma, diabetes, etc...) we should be aware of in order to better serve your child? (If none, please write "None known at this time."):

EMERGENCY CONTACT INFORMATION:

Emergency Contact Name: _____

Emergency Contact Name 2: _____

Emergency Contact Phone: _____

Emergency Contact Phone 2: _____

Relationship to Child: _____

Relationship to Child: _____