FAMILY INFORMATION/EMERGENCY MEDICAL AUTHORIZATION

Saint Catharine of Siena School, 2021-2022

SECTION I: FAMILY INFORMATION

The purpose of this section of the form is to gather student and parent information for school use and for use in our Student Directory. The Student Directory is distributed to all school families. The Directory will include Student Name and Grade along with Street Address, Home Telephone and Parent E-Mail and Cell Phone Information. Please Note: Information from this section will be shared with our PTA and Athletic Association.

Student's Last Name: _____ **First Name:** _____
Date of Birth: _____ **Grade for 2021-2022 School Year:** _____
Street Address: _____ **Zip Code:** _____
Home Telephone Number: _____

RESIDENTIAL PARENT OR GUARDIAN CONTACT INFORMATION

Mother's Name: _____ Mother's Daytime Phone No.: _____
Mother's Cell Phone Number _____
Mother's Email Address _____

Father's Name: _____ Father's Daytime Phone No.: _____
Father's Cell Phone Number _____
Father's Email Address _____

_____ **I do not want information from this section shared in the Student Directory, or given to the PTA or Athletic Association.**

SECTION II: EMERGENCY MEDICAL AUTHORIZATION

EMERGENCY CONTACT INFORMATION

The purpose of this section of the form is to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

In the event that a parent and/or guardian of your child cannot be reached, list the names of two people who may make decision in regard to your child:

Emergency Contact Name: _____ Relationship: _____
Daytime Telephone No.: _____
Address: _____

Emergency Contact Name: _____ Relationship: _____
Daytime Telephone No.: _____
Address: _____

(OVER – this is a two-sided form)

 Student Name: _____

EMERGENCY MEDICAL INFORMATION and AUTHORIZATION- (Complete Part 1 or 2)

PART 1: To Grant Consent for Treatment

In the event reasonable attempts to contact me have been unsuccessful, I hereby give consent for (1) the administration of any treatment deemed necessary by above named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. The authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Name of Doctor: _____ Telephone No.: _____
Name of Dentist: _____ Telephone No.: _____
Medical Specialist: _____ Telephone No.: _____
Hospital: _____ Emergency Room No._____

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments or conditions to which a physician should be alerted:

Allergies _____

Medications _____

Other Conditions _____

_____ **CHECK HERE IF YOUR CHILD HAS NO KNOWN ALLERGIES OR TAKES NO DAILY MEDICATIONS**

Signature of Parent/Guardian _____ Date _____

PART 2: REFUSAL TO CONSENT (Do not complete Part 2 if you completed Part 1)

I do NOT give my consent for the emergency medical treatment of my child. In the event of illness or injury Requiring emergency treatment, I wish the school authorities to take the following actions:

_____

Signature of Parent/Guardian _____ Date _____

The administration of Saint Catharine School may share this information on a need-to-know basis. Copies of this form will be made by the school as needed.