

**AUTHORIZATION FOR EMERGENCY MEDICAL AND/OR SURGICAL TREATMENT  
(THIS FORM MUST BE NOTARIZED IN ORDER TO BE VALID)**

**Parents:**

For our records, please complete all pertinent information below. This information will be placed in our files and used only in case of emergency.

STUDENTS NAME: \_\_\_\_\_ AGE/BIRTHDATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_ OTHER PHONE: \_\_\_\_\_

FAMILY DOCTOR: \_\_\_\_\_ PHONE: \_\_\_\_\_

FAMILY DENTIST: \_\_\_\_\_ PHONE: \_\_\_\_\_

HOSPITAL: \_\_\_\_\_ PHONE: \_\_\_\_\_

Do you have medical insurance coverage? \_\_\_\_\_ If yes, please list insurance company or plan information.

INSURANCE COMPANY: \_\_\_\_\_

CONTRACT NUMBER: \_\_\_\_\_ GROUP NUMBER: \_\_\_\_\_

**PLEASE NOTIFY IN CASE OF EMERGENCY:**

1. PARENT: \_\_\_\_\_ PHONE: \_\_\_\_\_ CAR: \_\_\_\_\_

2. OTHER: \_\_\_\_\_ PHONE: \_\_\_\_\_ CAR: \_\_\_\_\_

3. OTHER: \_\_\_\_\_ PHONE: \_\_\_\_\_ CAR: \_\_\_\_\_

BEEPER AND/OR OTHER NUMBERS: \_\_\_\_\_

PLEASE LIST ANY ALLERGIES, OR CHRONIC PHYSICAL OR EMOTIONAL CONDITIONS OF WHICH THE STAFF SHOULD BE AWARE:

**AUTHORIZATION**

In case of emergency, I hereby authorize the doctor listed above, or qualified staff of the hospital listed above, to perform any emergency medical procedure on my child, including surgery and/or the administration of anesthesia, as they deem medically necessary, in any emergency resulting from my child's participation in an extra-curricular athletic event as a member of a St. Michael School sports team. In the event the doctor listed above is not available, or the hospital listed above is not accessible, I so authorize any qualified medical personnel.

The authorization granted by this form will be used only if absolutely necessary and only after every attempt has been made to contact the parent or guardian. Doctors and hospitals can refuse to give treatment, regardless of how minor, unless they have authorization from the parent or guardian. As time can be essential in a medical emergency, this would assure your child of prompt, professional attention.

If the administration of any drug is contraindicated due to allergic reaction or other known physical condition, please list:

Date of last tetanus shot: \_\_\_\_\_

This authorization is effective from: \_\_\_\_\_ until: \_\_\_\_\_

Parent's Signature: \_\_\_\_\_

WITNESS: I hereby certify that this release form was signed in my presence.

Notary Public: \_\_\_\_\_ Date: \_\_\_\_\_