# EMERGENCY CONTACT & MEDICAL INFORMATION
# 2019-20

Child's name: ____________________________ Date of Birth: _________________

Parent's name (s) : _____________________________________________

Contact phone # during Religious Education hours: ______________/ _____________

**Medical/Special needs information:**

Allergies: _____________________________________________________

Medicines: _____________________________________________________

Chronic Condition/Disability: ________________________________________

Learning Challenge / Disability: ___________________________________________

**EMERGENCY INFORMATION:**

*In case of emergency, if parents/legal guardian cannot be reached, contact:*

Name: ________________________________ Relationship: _________________

Phone: ______________________________

Doctor: __________________________ Phone: _____________________

Dentist: __________________________ Phone: _____________________

*If you and the physician of your choice as indicated above, cannot be reached in an emergency, and, if in the judgment of the Rel Ed coordinator immediate medical and/or hospital attention is indicated, do you authorize the coordinator to send your child (properly accompanied) to an available hospital or physician?*

***______Yes*** ***_____ No*** _____________________________________________

*Parent's signature required* *Date*

*As a parent and/or legal guardian, I authorize the treatment of my minor child/children by a qualified and licensed medical doctor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause physical disability, or cause undue discomfort if delayed. I agree to assume the financial responsibility for any diagnosis, treatment, and/or medication deemed necessary. This consent is granted only after reasonable effort has been made to reach me.*

_____________________________________________________________________

*Parent's signature* *Date*