

**ST. JOHN THE EVANGELIST
EMERGENCY MEDICAL FORM**

Child's Name _____ Birthdate _____

Address _____ Home Phone _____

City _____ Zip _____

Mother's Name _____ Cell Phone _____

Employer _____ Business Phone _____

Father's Name _____ Cell Phone _____

Employer _____ Business Phone _____

Parents: Married ___ Divorced ___ Deceased ___ Remarried ___ Separated ___

Child lives with: _____

Family Doctor's Name _____ Phone _____

Hospital Preference _____

Allergies or Medical Problems or Medicines taken regularly _____

Has your child been diagnosed with a learning disability or attention deficit disorder? Specify:

Date of last Tetanus Vaccine _____ Immunizations up to date? Yes ___ No ___

Please list the names and phone numbers of **two** responsible persons we may contact in and emergency.

Name _____ Phone _____ Relation _____

Name _____ Phone _____ Relation _____

Authorization for Treatment of Minor

Date _____

I, _____ being the parent or legal guardian of _____

give my consent for emergency medical and surgical treatment of this minor in a licensed hospital by a licensed Indiana physician should his/her conditions so require it in my absence. I understand that in such case reasonable attempts would first be made to contact me, time and conditions permitting.

As long as the medical or surgical treatment considered necessary in the situation is in accordance with generally accepted standards of medical practice for the particular type of injury or illness involved, I impose no specific limitation or prohibitions regarding treatment other than those that follow. If none, so state, I assume financial responsibility for the same.

Limitations: _____

This authorization is effective for the following period: From August 2011 to September 2012.

Father's signature

Mother's signature