EMERGENCY MEDICAL RELEASE AND CONTACT INFORMATION FORM

Grade: _____

Last Name First Name Middle Initial

Home Street Address City State Zip Code

Home Telephone (____)_____ Date of Birth _____ Age _____ Gender: ❑ M ❑ F

Father's Name Father's Employer Father's E-mail Address

Father's Home Phone Father's Day Phone Father's Cell Phone

Mother's Name Mother's Employer Mother's E-mail Address

Mother's Home Phone Mother's Day Phone Mother's Cell Phone

ADDITIONAL MAILING ADDRESS (If a second parent/guardian requires school mailings):

Parent/Guardian Name Relationship

Street Address City State Zip Code

EMERGENCY CONTACTS – In the event that a parent cannot be reached, the individuals below have the authorization to pick up my child and can be reached during school hours at the number(s) listed below (please list in order of preference to be called):

1) Name Relationship Daytime Telephone

2) Name Relationship Daytime Telephone

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR:

I/We, the undersigned parent(s)/guardian(s) of _____, a minor, do hereby authorize Seton Catholic High School (Administrative/Staff member as agent(s)) for the undersigned to consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medical Practice Act on the medical staff of any hospital, whether such diagnosis or treatment is rendered at the office of said physician or said hospital. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment of hospital care which aforementioned physician in the exercise of his/her best judgment may deem advisable.

Insurance Co: _____ Employer: _____

Group #: _____ Policy #: _____

Primary Physician/Provider: _____ Physician Phone: _____

Hospital of choice in case of emergency:

List: Chronic illness of allergies: _____

Current Medications: _____

Last DPT Immunization: _____

Parent/Guardian Name (Please Print) **Parent/Guardian Signature** **Date**