

**ST. IGNATIUS PROGRAM
EMERGENCY FORM**

Please Print Family Name Home Telephone Number

Student Name _____ DOB _____ GR _____
(Last) (First)

Student Name _____ DOB _____ GR _____

Student Name _____ DOB _____ GR _____

Address _____ City _____ Zip _____

Mother/Guardian's Name _____ Work # _____

Address _____ City _____ Zip _____

Cell # _____ E-Mail _____

Father/Guardian's Name _____ Work # _____

Address _____ City _____ Zip _____

Cell # _____ E-Mail _____

ANY HEALTH CONDITIONS OR ALLERGIES WE SHOULD BE AWARE OF:

In case of emergency (when parents cannot be reached), please contact:

Name _____ Hm# _____ Wk# _____ Cell# _____

Name _____ Hm# _____ Wk# _____ Cell# _____

Physician _____ Hospital _____
Name Phone

Dentist _____
Name Phone

AUTHORIZATION FOR CONSENT OF TREATMENT OF MINOR

In the event of serious emergency and none of the persons listed can be contacted, I authorize school officials to call my family physician, or if the situation demands, to transfer my child to the nearest hospital for emergency care. I consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment which is deemed advisable by, and rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act, whether such diagnosis or treatment is rendered at the physician's office or at a certified hospital.

I hereby agree to bear all costs incurred as a result of the foregoing:

Signature of Parent Date

I do not choose to sign the above statement. In the event of an accident of emergency, please:

MEDICAL INSURANCE COVERING THE STUDENT: _____
Name of Company Policy No.