



# EMERGENCY PROCEDURE CARD

Family Name: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_

Student _____	_____	_____	_____	_____
	Last Name	First Name	Grade	Allergic to

Student _____	_____	_____	_____	_____
	Last Name	First Name	Grade	Allergic to

Student _____	_____	_____	_____	_____
	Last Name	First Name	Grade	Allergic to

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Mother's Work # \_\_\_\_\_ Father's Work # \_\_\_\_\_

Mother's Cell # \_\_\_\_\_ Father's Cell # \_\_\_\_\_

If we cannot be reached at the above numbers, you have my permission to contact the following people:

\_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

\_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Name of Family Physician \_\_\_\_\_ Phone # \_\_\_\_\_

I understand that the school does not assume responsibility for payment of a physician. If our family physician cannot be reached, the school may choose a physician. Yes \_\_\_\_\_ No \_\_\_\_\_

### AUTHORIZATION OF CONSENT FOR TREATMENT OF MINOR

In the event of serious emergency, and none of the persons listed above 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 surgical 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 cost incurred as a result of the above circumstances.

Parent signature \_\_\_\_\_ Date \_\_\_\_\_

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

\_\_\_\_\_

Parent signature \_\_\_\_\_ Date \_\_\_\_\_