**Emergency and Incidental Medical Treatment**

In the event of an emergency, I give permission to transport my child, _____, to a hospital for emergency medical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, please contact:

**Name:**_____

**Relationship:** _____

**Phone numbers - Home:** _____ **Work:**_____

**Cell:**_____

I further understand that if I cannot be reached, or if the emergency contact that I have listed above cannot be reached, and my child/ward is in need of immediate medical care, St. Francis Xavier Parish reserves the right to make a temporary decision that is in the best interest of my child/ward until such a time when I can be reached.

**Please check the appropriate preference below.**

I give permission to chaperones of this event from the St. Francis Xavier Parish to distribute non-prescription/ over-the-counter medications and treatments to my child/ward such as, but not limited to: applying minor bandages and first-aid ointments or sprays, ice or heat compresses, dispensing of non-aspirin pain relievers, cough drops or syrups, and antacids and the like.

**Yes____ No____**

**Please supply all of the information requested below:**

Family Health Insurance Company:_____

Policy # : _____

Family physician or clinic:_____

Address: _____

Phone: _____

Family dentist: _____

Address: _____

Phone: _____

Date of most recent physical examination: _____

Current medications: _____

Dosage & Frequency: _____

Date of most recent tetanus immunization: _____

Known allergies: _____

Treatment for allergies: _____

Recent surgeries or serious illness: _____

Any other special needs to be noted: _____

_____

I verify that all of the medical information for my child/ward listed above is correct and current to the best of my knowledge at the time of the event described above. I have indicated all potential health issues for my child/ward (including medications and any special dietary needs), as well as indicated my preference to the distribution of non-prescription/over-the-counter medications and treatments such as: applying minor bandages and first-aid ointments or sprays, ice/ heat compresses, dispensing of non-aspirin pain relievers, cough drops or syrups, and antacids and the like.

Parent or guardian signature:_____

Date: _____