LITTLE FLOWER FOUNDATIONS/CHOSEN 2017 – 2018

Child Name: **Child Date of Birth:**

Parents Information:

Registering for: ☐ **Foundations (K-6) Sundays, 9:30 – 11:45 am**

☐ **Chosen (7 & 8) Second Sunday of each month 5:30 – 8:00pm**

School attending Fall 2017: _____**Grade:** _____

Sacraments Received: Baptism Y/N Reconciliation Y/N First Communion Y/N

There are times when pictures may be taken of your child for promotional purposes. Please indicate your preference, and sign:

Permission given ☐ **Permission not given** ☐ **Signature** _____

2017-2018 EMERGENCY MEDICAL AUTHORIZATION FORM

Purpose – to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school/parish authority when parents or guardians cannot be reached.

FIRST CONTACT

Residential Parent or Guardian

Mother's Name_____ Day Phone_____
First Last

Father's Name_____ Day Phone_____
First Last

Guardian Name & Relationship_____

Guardian Day Phone_____

SECOND CONTACT

Name_____ Day Phone_____

Relationship_____

_____

Does your child have a physical or medical condition or allergies that his/her teacher should be aware of? (Y/N)_____

Please explain _____

_____

_____

_____

_____

Is your child on any medication we should be aware of? (Y/N)_____ Please list: _____

_____

_____

CONTINUE ON REVERSE SIDE

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician_____ Phone_____

Dentist_____ Phone_____

Medical Specialist_____ Phone_____

Local Hospital_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

_____

_____

Signature of Parent/Guardian_____Date_____

PART II: REFUSAL TO CONSENT

I do **NOT** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

_____

_____

Signature of Parent/Guardian_____Date_____

Any additional comments?_____

_____

_____

Little Flower
CATHOLIC PARISH