

**The Franciscan School
Emergency Medical Authorization
2008-09 School Year**

Student's Name _____ Male ___ Female ___ Grade ___ DOB _____

Parent/Guardian Name _____ Home Phone _____

Work Phone Mother/Guardian _____ Work Phone Father/Guardian _____

Home Address _____

E-mail Address _____

Insurance Carrier _____ Policy # _____

In the event that the parent/guardian cannot be contacted, please contact:

_____ Phone _____

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury.

Preferred Physician _____ Phone _____

I understand that this authorization will only be enforced when I cannot personally be contacted and provide immediate treatment.

Signed (parent/guardian) _____ Date _____

Emergency Locater Card

Student's Name _____ Grade _____ DOB _____ Phone _____

Address _____

Student resides with: ___ mother/father ___ mother ___ father ___ mother/Stepfather ___ Father/stepmother
___ Guardian ___ Other (please explain) _____

Title: ___ Mr. & Mrs. ___ Dr. ___ Ms. ___ Mr. ___ Mrs. ___ Rev. Other _____

Mother/Guardian Name _____ Occupation _____ Work# _____

Cell# _____ Beeper _____

Employer _____ Address _____

Father/Guardian Name _____ Occupation _____ Work# _____

Cell# _____ Beeper _____

Employer _____ Address _____

Every effort will be made to contact the parent/guardian in the event of an emergency. If we are unable to contact the parent/guardian, emergency rescue will be called.