



AUTHORIZATION FOR EMERGENCY MEDICAL CARE

If I cannot be reached to make arrangements for emergency medical care for my child at the time of illness or accident, I give my permission for **The St. Anthony School** staff to take my child to the nearest medical facility for treatment.

Name of Child: _____ Date of Birth: _____

Name of Physician: _____ Physician Telephone: _____

Address of Physician: _____

I give my consent for necessary emergency treatment when my child is in the care of a physician, hospital or clinic.

Signature of Parent or Guardian: _____ Date: _____

Telephone: Home: (____) -- _____

Work: (____) -- _____

Cell: (____) -- _____