

## MEDICAL PERMISSION FORM

I grant permission for the administration of First Aid to my child by the people in charge of the St. Daniel the Prophet Religious Education Program and to those transporting my child to and from the activity as their judgement deems advisable, and to make the necessary referrals to qualified physicians for the treatment of illness or accidents of a more serious nature. I understand that I will be promptly notified in the event of any serious illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In case of medial emergency, I understand that every effort will be made to contact me. In the event that I cannot be reached, I hereby give permission to the physicians selected by the adult staff to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery, if deemed necessary.

Parent/Guardian Signature:

Date:

### CHILD #1 NAME:

Medication Allergies	Medications Being Taken	Other Allergies

### CHILD #2 NAME:

Medication Allergies	Medications Being Taken	Other Allergies

### CHILD #3 NAME:

Medication Allergies	Medications Being Taken	Other Allergies

### INSURANCE POLICY IN NAME OF:

Insurance Company	Policy Number	I.D.# or S.S.#
Authorized Physician		Phone #

### PARENT/GUARDIAN INFORMATION:

Name	Address
Home Phone:	Email Address
Cell Phone:	

### EMERGENCY CONTACT NAME:

Home Phone:	Email Address
Cell Phone:	