

CRISTO REY JESUIT EMERGENCY MEDICAL AUTHORIZATION FORM

Student's Name _____

School _____ Sport(s) _____

Date of Birth _____ Age _____ Gender _____

Parent/Guardian _____

Address _____

Home Phone _____ Cell Phone _____

In the event that I cannot be reached, please contact:

Emergency Contact #1 _____ Relationship to Student _____

Home Phone _____ Cell Phone _____

Emergency Contact #2 _____ Relationship to Student _____

Home Phone _____ Cell Phone _____

Medical Insurance Company: _____

Medical Insurance Policy Number: _____

List any physical disabilities or Allergies: _____

List any other information needed: _____

AUTHORIZATION OF EMERGENCY MEDICAL TREATMENT

We authorize the Cristo Rey Jesuit High School representative, to provide and secure any medical assistance on behalf of my son/daughter. I authorize these individuals to discuss my son's/daughter's medical condition with other health care personnel whom they deem appropriate. We further authorize transportation by Emergency Medical Service Personnel to an Emergency Management Facility (hospital) and the Emergency Management Facility to treat the condition in the event that we are physically unable to give consent ourselves.

Signature of Parent/Guardian:

Date