

## **PERMISSION FOR EMERGENCY TREATMENT**

Parents should notify the office if any changes occur regarding the information on the form during the school year.

St. Michael the Archangel High School has my permission to seek emergency medical treatment for my child in the event I cannot be reached. In cases of extreme emergency, my child may be taken to the nearest medical facility and treated by the on-call physician. Parents are responsible for any bill incurred in seeking treatment.

Student Name: \_\_\_\_\_ Student Signature: \_\_\_\_\_

Date: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

Home Phone: (Mother) \_\_\_\_\_ (Father) \_\_\_\_\_

Work Phone (Mother) \_\_\_\_\_ (Father) \_\_\_\_\_

***Name and phone number if parents cannot be reached:***

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

**PHYSICIAN'S NAME:** \_\_\_\_\_ **Office Phone:** \_\_\_\_\_