EMERGENCY MEDICAL INFORMATION
St. Peter PSR

OFFICE USE ONLY

Grade _______________ Time ___________________

Room _______________ Birth date ________________

Is EPI-PEN required? Yes No

Location of EPI-PEN

Student Name ____

Address ____

Email Address ____

Name ____ Mother Home Phone ___________________________

Cell Phone ___________________________

Work Phone ___________________________

Name ____ Father Home Phone ___________________________

Cell Phone ___________________________

Work Phone ___________________________

Name ____ Other Home Phone ___________________________

Cell Phone ___________________________

Relationship ________________________ Work Phone ___________________________

In the event reasonable attempts to contact the above-mentioned have been unsuccessful, I hereby give my consent for: the administering of any treatment deemed necessary by:

1. Preferred Physician ______________________________________ Phone __________________________________

2. M.D. Specialist ____ Phone __________________________________

1) In the event a parent or designated preferred practitioner are not available, the PSR staff will call 911.

2) The transfer of the child to (Preferred hospital) ____ or any hospital reasonably accessible.

SIGNATURE OF LEGAL GUARDIAN ____ ***DATE*** _____________________

Food Allergies ____ Medicine Allergies __________________________________

Insect Allergies ____ Other Allergies ____________________________________

Is EPI-PEN Required? _____________________________ Will EPI-PEN be kept with child ____________________

in classroom ____________________

in PSR office ____________________

If EPI-PEN is kept at St. Peter, during class time, it must be in a sealed container and clearly labeled with the child's name, age, contact phone numbers, symptoms to look for, dispensing instructions, and a **current photo of the child.

Current Medications

____

Health Concerns (Diabetes, Asthma, Contacts, Etc.)

____

I release St. Peter PSR and St. Peter Church, staff and volunteers from all liability that may arise from any emergency.

Signature of Parent or Guardian: ____**date**________________________

REFUSAL TO CONSENT: I do not give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment I wish St. Peter authorities to TAKE NO ACTION OR TO:

____

Signature of Legal Guardian ____ Date ______________________