

**OUR LADY OF MOUNT CARMEL RELIGIOUS EDUCATION
EMERGENCY INFORMATION**

<u>CHILD'S NAME</u>	<u>LEVEL</u>	<u>CATECHIST'S NAME (Leave blank)</u>
1: _____ Last name First	_____	_____
2: _____ Last name First	_____	_____
3: _____ Last name First	_____	_____
4: _____ Last name First	_____	_____

CONTACT INFORMATION

_____	_____	_____	_____
Name of contact person	Phone #	Doctor's Name	Phone #

_____	_____	_____	_____
Name of alternative # 1	Phone #	Name of alternative # 2	Phone #

Hospital Preferred

_____	_____
Parent's Signature	Date

MEDICAL RELEASE

In the event that the undersigned, or my (our) authorized physician cannot be reached and in the judgment of Director of Religious Education or other person responsible for the program/group, or other appropriate staff member, there is a necessity for immediate examination and/or treatment of my (our) child. I (we) hereby request and authorize any of the said personnel to obtain for my child such medical services as are deemed necessary. I agree to assume the financial responsibility for any diagnosis/treatment and for medication deemed necessary.

_____	_____
Parent/Guardian's Signature	Date