

PARENTAL PERMISSION FOR EMERGENCY MEDICAL CARE

Saint Andrew's School

**NOTE: THIS FORM MUST BE DATED, SIGNED, AND NOTARIZED
BETWEEN JUNE 5TH AND AUGUST 8TH.**

The undersigned patient (a student at Saint Andrew's School) and parents/guardians consent to the transportation to the appropriate facility, and authorization by an administrator or faculty representative of Saint Andrew's School, for any and all emergency medical, psychological, dental or surgical treatments, including anesthesia and operations which may be deemed advisable by the attending physician or dentist, should any of such treatments be deemed advisable or necessary on account of illness, accident or injury incurred or sustained while the patient is attending school, participating in any school activity, including any practice, training or competition in athletic activities, on or off campus, or otherwise under the supervision of Saint Andrew's School. The intention hereof is to grant authority to administer and to perform all examinations, treatments, anesthetics, operations and diagnostic procedures which may now or during the course of the patient's care be deemed advisable or necessary. We also agree that the patient when admitted to a hospital is to remain in the hospital until his or her physician recommends the patient's discharge. We further understand that Saint Andrew's School will, in any event where emergency room or hospital treatment for a student is indicated, use due and prompt diligence to notify, and where appropriate, consult with a parent or guardian. We further agree to pay and hold Saint Andrew's School harmless on account of any reasonable medical, dental, or hospital or other related charges incurred on behalf of the patient.

Student's Name: _____ <small>(Please Print)</small>	Date of Birth: / /
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Parent or Guardian's Signature: _____	Date: _____
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Address: _____ Street	City	State	Country	Zip
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Emergency Phone #(s):				
()	()	()	()	()
Father's Home	Father's Work	Father's Cell	Father's Fax	
()	()	()	()	()
Mother's Home	Mother's Work	Mother's Cell	Mother's Fax	

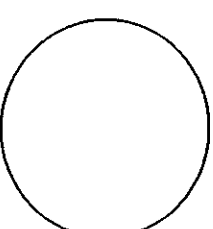
Other emergency contacts for information, not permission:		
Name: _____	Address: _____	Phone: ()

Family Doctor:		
Name: _____	Address: _____	Phone: ()

Insurance Information:			
Company Name: _____	Address: _____	Phone: ()	
Group Number (if applicable): _____	Policy Number: _____	Type of Coverage (i.e. HMO/PPO): _____	

State of Florida
County of _____

The foregoing instrument was acknowledged before me on this _____ day of _____, 20__ by _____ who is personally known to me or who has produced the following identification: _____



NOTARY SEAL

Notary Public _____ Date _____
Please use the enclosed envelope to mail all forms to the school nurse. (561) 210-2080