Emergency Procedure Form
Our Lady of Assumption Extended Care Program

Please write clearly and fill in all information available.

Student #1: _____ _____ _____ _____ _____
Last Name *First Name* *Birth date* *Grade* *Allergies*

Student #2: _____ _____ _____ _____ _____
Last Name *First Name* *Birth date* *Grade* *Allergies*

Student #3: _____ _____ _____ _____ _____
Last Name *First Name* *Birth date* *Grade* *Allergies*

Address _____ _____
Street *City* *Zip* *Home Phone#*

Mother: _____ _____
Last Name *First Name* *Home Phone#*

Home Address (if different from Student's) _____
Street *City* *Zip*

Business Address _____
Job Title/Organization *Street* *City* *Zip*

Business Phone _____ ext.____ Cell #_____ **E-Mail** _____

Father: _____ _____
Last Name *First Name* *Home Phone#*

Home Address (if different from Student's) _____
Street *City* *Zip*

Business Address _____
Job Title/Organization *Street* *City* *Zip*

Business Phone _____ ext.____ Cell #_____ **E-Mail** _____

Emergency Contacts:

If I cannot be reached at the above address, you have my permission to contact the following persons:

1._____Home Phone _____ Cell# _____Relationship_____

2. ._____Home Phone _____ Cell# _____Relationship_____

3._____Home Phone _____ Cell# _____Relationship_____

Physician: _____ Phone _____

I understand that OLA Extension does not assume responsibility for payment of a physician. If our family physician cannot be reached, refer to the physician on call. Yes_____ No_____

Hospital Preferred: _____ Address: _____

Health Insurance Coverage: Provider _____ Member I.D. # _____

Authorization of consent for treatment of a minor

In the event of a serious emergency, and none of the persons listed above can be contacted, I authorize OLA Extended Care officials to call my family physician, or if the situation demands, to transfer my child to the nearest hospital for emergency care. I consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment which is deemed advisable by, hand rendered under the general or special supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act, whether such diagnosis or treatment is rendered at the physician's office or at a certified hospital.

__ I hereby agree to bear all costs incurred as a result of the foregoing.

__ I do not chose to sign the above statement. In the event of an accident or emergency please:

_____

_____

My child(ren) have permission to take __ acetaminophen_____ mg . / __ Ibuprofen_____ mg. During the 2007-2008 school year. Yes__ No __

Parent Signature: _____ **Date:** _____

Pick Up List

Our Lady of the Assumption Extended Care Program

Individuals listed are allowed to pick my student(s) up from Extension. Additions and alterations can be made to this at any time as long as a staff person is contacted by the student's legal guardian. ID is required for the first time pickups.

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Name

Name

Name

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