SAINT ALBANS SCHOOL

AN INDEPENDENT SCHOOL IN THE ANGLICAN TRADITION

EMERGENCY CONTACT FORM AND AUTHORISATION FOR EMERGENCY MEDICAL TREATMENT

Student's Name _____ Grade_____

In an emergency, I request that, in my absence, the above-named child be admitted to any emergency medical care center for diagnosis and treatment. I hereby give my permission for Saint Albans School to transport my child to any facility for any needed treatment to be provided upon the advice of a physician, surgeon, or dentist licensed to practice medicine under the laws of the State of New York.

IN GIVING THIS CONSENT, I RECOGNIZE AND UNDERSTAND that I give permission to evaluate the risks involved and to select the necessary treatment from any available alternatives and to provide such care and perform such treatment as that physician, surgeon, or dentist in his professional judgment deems necessary to assure the health and safety of the above-named minor.

Father's Name _____

Cell Phone_____ Work Phone _____

Mother's Name_____

Cell Phone _____ Work Phone _____

Nearest Relative (not a parent) _____

Relationship to Child _____

Cell Phone _____ Work Phone _____

_____ _____

Signature of parent or guardian Date

_____ _____

Signature of parent or guardian Date