



Authorization for Emergency Medical Care

Child's Name _____

Date of Birth: _____ Age: _____

Address _____
Street City Zip

Home Phone: _____

Mother's Name: _____ Cell Phone: _____

Father's Name: _____ Cell Phone: _____

Local friend or close relative _____

Address: _____

Home Phone: _____ Cellular Phone: _____

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Any known allergies requiring special attention: _____

Any restrictions that should be observed: _____

Date of last Tetanus shot: _____

Prescriptions taken on a regular basis: _____

Physician: _____ Phone: _____

Address: _____

Dentist: _____ Phone: _____

Address: _____

Hospital preference: _____

Health Insurance Group: _____ Number _____

I hereby waive any claim against the Good Shepherd Episcopal Church / School.

I hereby grant permission for the Director, Staff person, teacher, Priest, or an authorized counselor to take whatever steps which may be necessary to obtain emergency medical care if warranted. These steps may include, but are not limited to the following:

1. Attempt to contact parents or guardians through the numbers listed on this form.
2. Attempt to contact the child's physician.
3. If we cannot contact you or your child's physician, we will do any one or all of the following:
 - a. call another physician or paramedics,
 - b. call an ambulance,
 - c. Have the child taken to an emergency hospital in the company of a staff member.
4. Any expenses incurred under 3 above will be borne by the child's family.
5. The church will not be responsible for anything that may happen as a result of false or omitted information given at the time of registration.

Signature of parent or guardian

Date

STATE OF TEXAS

COUNTY OF HARRIS

Before me, the undersigned authority, on this day personally appeared

known to me to be the person whose name is subscribed above, and acknowledged to me that he/she executed the same for the purpose therein expressed.

Sworn and subscribed before me this _____ day of _____, _____.

Notary Public

(Seal)