

MDCS Permission for Emergency Treatment and Screening 2022-2023

PERMISSION FOR EMERGENCY TREATMENT

To Whom It May Concern:

Mater Dolorosa Catholic School has my permission to seek emergency medical treatment for _____ in the event I **cannot be reached**. My child may be taken to the nearest medical facility in the event his/her Physician Name: _____, Physician phone # _____, is not available.

In case of emergency, I will be responsible for any bill incurred while receiving treatment and transportation. In the event of school directed emergency treatment, **be advised my child is allergic to:** _____

(Please print allergic information)

SIGNATURE and Name of Parent/Guardian

Physical Home Address _____ Home Phone _____

Work Phone # _____ Primary Emergency Number _____ Cell Phone Number for Primary Guardian _____

PERMISSION FOR SCREENING

Date _____

To Whom It May Concern:

I give permission for my child _____ (print student name) who is in the _____ grade to be screened for vision, hearing, speech and other health related issues.

SIGNATURE of Parent/Guardian
Name

Print Guardian

