

Return by August 1 to SMA

**St. Mary's Academy**  
Emergency & Contact Form 2016-2017

**Student Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

I, parent or legal guardian of \_\_\_\_\_, a minor child, hereby give my consent for emergency medical, surgical, or dental treatment in the event of accident, injury, sickness, or other event of an emergency nature, which would require immediate treatment. I understand that St. Mary's Academy will notify me as soon as possible of its actions with regard to such treatment, as soon as circumstances permit. I acknowledge that my student's medical information may be shared with appropriate medical staff when necessary in compliance with HIPPA (Health Insurance Portability and Accountability Act) regulations.

I hereby release St. Mary's Academy and its employees, including faculty, staff and maintenance personnel, from any liability by reason of the exercise of emergency medical, surgical, or dental treatment pursuant to this release, except liability for bad faith in the exercise thereof. I further understand that there is no limitation to the treatment that may be used, as long as it is within the standards of generally accepted medical, surgical or dental practice, and I have listed below any limitations with respect to prohibitions of treatment, specific allergies, drugs, etc.

\_\_\_\_\_  
**Father's Signature (or legal guardian)**

\_\_\_\_\_  
**Mother's Signature (or legal guardian)**

\_\_\_\_\_  
**Cell Phone Number**

\_\_\_\_\_  
**Cell Phone Number**

\_\_\_\_\_  
**Home Phone**

\_\_\_\_\_  
**Work Phone**

\_\_\_\_\_  
**Home Phone**

\_\_\_\_\_  
**Work Phone**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**Address**

\_\_\_\_\_  
**City/State/Zip**

\_\_\_\_\_  
**City/State/Zip**

\_\_\_\_\_  
**E-mail Address**

\_\_\_\_\_  
**E-mail Address**

**If unable to contact either parent, please contact:**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Phone**

**Known Allergies, Chronic Illnesses and Recent Injuries:** \_\_\_\_\_

**Medications/ Other:** \_\_\_\_\_

\_\_\_\_\_  
**Medical Insurance Carrier**

\_\_\_\_\_  
**Family Doctor**

\_\_\_\_\_  
**Insured Member's Name**

\_\_\_\_\_  
**Phone**

\_\_\_\_\_  
**Policy Number**

\_\_\_\_\_  
**Hospital Preference**

**I grant permission for my child to take Tylenol/Ibuprofen when needed, in the recommended dosage, administered by an adult in the division office. I release St. Mary's Academy from responsibility for any adverse consequences which may result when this procedure is followed.**

\_\_\_\_\_  
**Parent Signature**

\_\_\_\_\_  
**Date**