St. Michael's Country Day School

AUTHORIZATION FOR EMERGENCY MEDICAL AND/OR SURGICAL TREATMENT AND RELEASE

Students Name:_____ Grade:_____

Parent / Guardian 1:_____
(name) (phone number)

Parent / Guardian 2:_____
(name) (phone number)

Student's Physician: name and phone number:_____
(name) (phone number)

Name of preferred Hospital: _____
(i.e., Newport, Hasbro, "closest," etc.)

As the parent or guardian of _____, a St. Michael's Country Day student, I hereby authorize and consent, in the case of accident or illness, to any and all emergency treatment deemed necessary for the safety and well being of the above student, by officials or employees of St. Michael's Country Day School and physicians / medical personnel engaged to provide emergency treatment. Under such emergency circumstances, I further authorize any designated licensed physician/hospital to undertake such care and treatment of my child as is deemed necessary to sustain life, including any x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment. I understand that St. Michael's Country Day School shall make reasonable efforts to contact parent(s) or guardian before arranging for or providing emergency medical assistance, except when immediate attention is necessary.

I assume responsibility for all medical expenses incurred on behalf of the student.

Parent or Guardian:_____ Date: _____
(Print) (Signature)