

HOLY ANGELS CHURCH  
324 South Ohio Avenue  
Sidney, Ohio 45365

**EMERGENCY MEDICAL AUTHORIZATION**

**FAMILY NAME** \_\_\_\_\_ **FATHER** \_\_\_\_\_ **MOTHER** \_\_\_\_\_

**STUDENT(S) NAME & GRADE** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**Purpose** — to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while attending Youth Program Activities, when parents or guardians cannot be reached.

In case of accident or serious illness, if I cannot be reached at the above address, you have my permission to contact either of the emergency contacts below.

\_\_\_\_\_  
(Signature of parent or guardian)

**FAMILY DOCTOR** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**EMERGENCY HOSPITAL** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**EMERGENCY CONTACTS:** *(MUST give 2 OTHER THAN PARENTS)*

**NAME** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**NAME** \_\_\_\_\_ **RELATIONSHIP** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_ **PHONE** \_\_\_\_\_

**Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_