EMERGENCY MEDICAL CARE

Student Name(s)____

School: **ST. VINCENT DE PAUL CACHOLIC SCHOOL**

Address: **1315 West Cypress Street**

Rogers, AR 72758

In case of emergency, if the undersigned parent(s) or guardian cannot be reached at the telephone numbers on file at the school, consent is given to take any of my/our children to

____or

____

The aforementioned doctor, or, in the event of his unavailability, any doctor on the staff of said hospital, is authorized to utilize whatever medical techniques are deemed necessary, including surgery. The undersigned acknowledge their responsibility for all Reasonable medical expenses so incurred.

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Parent or other Guardian

Emergency Contacts (other than parents)

First contact	Second contact
Name: ______________________	Name: ______________________
Relation: ______________________	Relation: ______________________
Phone: __________ Cell: __________	Phone: __________ Cell: __________

Medical Doctor/Clinic______________________________Phone Number______________________

Dentist____________________________________Phone Number______________________

Insurance Company______________________________Policy No.____________________________