

SERVICE DAY  
SAINT CLEMENT PARISH  
APRIL 26, 2008

**EMERGENCY AUTHORIZATION**  
**ONE FORM PER CHILD PLEASE**  
(please print or type)

Student's full legal name \_\_\_\_\_

Legal home address \_\_\_\_\_

Date of birth \_\_\_\_\_ S.S.N. \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ work (M) (\_\_\_\_) \_\_\_\_\_ work (F) (\_\_\_\_) \_\_\_\_\_

Cell phone (M) (\_\_\_\_) \_\_\_\_\_ (F) (\_\_\_\_) \_\_\_\_\_

**We ask that all parents participating in Service Day off campus carry a cell-phone in case of an emergency.**

Emergency relative \_\_\_\_\_ phone # (\_\_\_\_) \_\_\_\_\_

Emergency physician \_\_\_\_\_ phone # (\_\_\_\_) \_\_\_\_\_

Allergies (food, medication, bee sting, etc.) \_\_\_\_\_

IN CASE OF AN EMERGENCY INVOLVING MY CHILD, AND A PARENT/GUARDIAN CANNOT BE CONTACTED, I AUTHORIZE **DONNA TERRASI OR ANNE ROG** (Saint Clement teacher and principal) TO OBTAIN MEDICAL CARE FOR MY CHILD. I UNDERSTAND THAT MY CHILD WILL BE TAKEN TO CHILDREN'S MEMORIAL HOSPITAL. FURTHERMORE, IF THE TREATMENT IS NECESSARY FOR ILLNESS OR INJURY, I AUTHORIZE THE USE OF OUR FAMILY MEDICAL INSURANCE COMPANY.

Company name \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Policy # \_\_\_\_\_ Billing address \_\_\_\_\_

Employer \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Parent/guardian name \_\_\_\_\_

Parent/guardian signature \_\_\_\_\_

**DOCTOR'S AUTHORIZATION IS REQUIRED FOR THE FOLLOWING SECTION:**

Daily Medication (include name of drug and consumption schedule) \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

This form must be returned to Saint Clement Church by **April 23, 2008**. Attention: Service Day