St. Colette
Parish School of the Catholic Formation
Renewal Registration

Circle one: In School or Home School

Child's Name | Circle one : Male/ Female | Grade in September

Street Address | City/State | Zipcode

Home Phone | Email

COMPLETE EITHER PART I OR II BELOW

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact a parent/guardian have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by the designated preferred physician or dentist, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and the transfer of the child to the preferred hospital reasonably accessible.

Mother/Guardian: ______________________ Phone: ______________

Father/Guardian: ______________________ Phone: ______________

Name of Other Person to Contact: ______________________

Relationship to Child: ______________________ Phone: ______________

Preferred Physician: ______________________ Phone: ______________

Preferred Dentist: ______________________ Phone: ______________

Medical Specialist (If applicable): ______________________ Phone: ______________

Preferred Hospital: ______________________ Phone: ______________

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

FACTS CONCERNING THE CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES, MEDICATIONS BEING TAKEN, PHYSICAL IMPAIRMENTS, LEARNING IMPAIRMENTS (ADD/ADHD) THAT WE OR A PHYSICIAN SHOULD KNOW:

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Parent/Guardian Signature: ______________________ Date: ______________

PART II: REFUSAL TO CONSENT (DO NOT COMPLETE IF YOU HAVE SIGNED PART I)

I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment. I wish the school authorities to take the following action:

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Parent/Guardian Signature: ______________________ Date: ______________