

Our Lady of the Assumption Faith Formation  
Emergency Card 2011-2012  
Please Print

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Medical condition, problems or food allergies for this child:  
\_\_\_\_\_

\*\*\*\*\*

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Medical condition, problems or food allergies for this child:  
\_\_\_\_\_

\*\*\*\*\*

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Grade: \_\_\_\_\_

Medical condition, problems or food allergies for this child:  
\_\_\_\_\_

\*\*\*\*\*

**Contact Information**

Name of person to notify in case of an emergency: \_\_\_\_\_

Relationship to child(ren): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Where will this person usually be during Faith Formation Classes? \_\_\_\_\_ (Home, office, car waiting, specify other)

Name of another responsible adult we may contact: \_\_\_\_\_

Relationship to child(ren): \_\_\_\_\_ Phone Number: \_\_\_\_\_

Where will this person usually be during Faith Formation Classes? \_\_\_\_\_ (Home, office, car waiting, specify other)

---

**Authorization of Consent for Treatment of a Minor**

In the event of a serious emergency and none of the persons listed on this form can be contacted, I authorized Faith Formation officials to call my family physician, or if the situation demands, to transfer my child to the nearest hospital for emergency care. I consent for any x-ray examination, anesthetic, medical or surgical diagnosis or treatment which is deemed advisable by and rendered under the general or supervision of any physician and surgeon licensed under the provisions of the Medicine Practice Act whether such diagnosis or treatment is rendered at the physician's office or at a certified hospital.

I understand that the Our Lady of the Assumption Faith Formation Program does not assume responsibility for payment of medical treatment.

I hereby agree to bear all costs incurred as a result of the foregoing.

Parent's Name: (Print) \_\_\_\_\_

Parent's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If your physician cannot be reached, the Faith Formation Program may choose a physician:  
 Yes  No

If "NO" is checked, indicate what is to be done in case of an accident or emergency:

Signature: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_ Date: \_\_\_\_\_

---