

**OUR LADY OF MOUNT CARMEL RELIGIOUS EDUCATION  
EMERGENCY INFORMATION**

<u>CHILD'S NAME</u>	<u>LEVEL</u>	<u>CATECHIST'S NAME</u> (Leave blank)
1: _____ Last name                      First	_____	_____
2: _____ Last name                      First	_____	_____
3: _____ Last name                      First	_____	_____
4: _____ Last name                      First	_____	_____

**CONTACT INFORMATION**

_____	_____	_____	_____
Name of contact person	Phone #	Doctor's Name	Phone #
_____	_____	_____	_____
Name of alternative # 1	Phone #	Name of alternative # 2	Phone #

\_\_\_\_\_

Hospital Preferred

\_\_\_\_\_

Parent's Signature

\_\_\_\_\_

Date

**MEDICAL RELEASE**

In the event that the undersigned, or my (our) authorized physician cannot be reached and in the judgment of Director of Religious Education or other person responsible for the program/group, or other appropriate staff member, there is a necessity for immediate examination and/or treatment of my (our) child. I (we) hereby request and authorize any of the said personnel to obtain for my child such medical services as are deemed necessary. I agree to assume the financial responsibility for any diagnosis/treatment and for medication deemed necessary.

Dates for which release is intended: Year – 2011 – 2012

\_\_\_\_\_

Parent/Guardian's Signature

\_\_\_\_\_

Date