St. Peter Central Catholic Extended Day Program

MEDICAL INFORMATION AND CONSENT

Child's name: _____ Grade: _____
Last First
Child's name: _____ Grade: _____
Child's name: _____ Grade: _____

Physician: _____ Phone #'s _____
Address: _____
Preferred hospital in case of emergency: _____

- **Please list:**

  - Current health issues (illnesses, disabilities): _____
  - Special medical devices (orthodontics, respirator, etc.): _____
  - Past health problems: _____
  - Medications currently taken: _____
  - Allergies: _____
  - Activities in which your child **should not** participate: _____

- **Please identify any special circumstances regarding your child of which EDP staff should be aware:**

CONSENT TO PROVIDE MEDICAL TREATMENT TO MINOR CHILDREN

I _____ hereby give my permission
(Parent or legal guardian)
that my child/children _____
may be given emergency treatment, to include first aid and CPR, by a qualified staff member of St. Peter Central Catholic Extended Day Program.

I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by my child's regular physician, or when that physician cannot be reached, by a licensed physician or hospital when deemed immediately necessary or advisable by a physician to safeguard my child's health and I cannot be contacted. I waive my right to informed consent to such treatment.

I give my permission for my child to be transported by ambulance or aid car to the hospital to receive emergency treatment.

Signature _____ Date _____

(Please fill out the other side.)