



St. Andrew Academy After School Care Program

7724 Columbine Drive Louisville, Kentucky 40258 (502) 935-4578 ext. 239

PARENTAL EMERGENCY MEDICAL CONSENT FORM
This form must be presented upon admission for treatment

Child's Full Name _____ Date of Birth _____

In the event that my child (listed above) may require emergency medical care, I hereby give my consent for my child to receive medical treatment at _____ (preferred hospital) or the closest hospital available if necessary.

My child's primary physician is _____ at _____

Address _____ Phone #: _____

I agree to pay all the costs and fees contingent on any emergency medical and/or treatment for my child as secured or authorized under this consent.

The St. Andrew Academy After School Care Program states that every effort will be made to notify parent/guardian immediately in case of an emergency.

Child's Allergies: _____

Other Medical Concerns:

Routine Medications:

Last Tetanus Shot: _____

Child's Social Security Number
_____-_____-_____

Medical Insurance Company: _____

Group Number: _____ ID Number: _____

This consent will be in affect beginning (date) _____ and continuing while the child is enrolled in the St. Andrew Academy After School Care Program.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Signature _____ Date _____