

EMERGENCY RELEASE/AUTHORIZATION FORM

Print Name	Home Phone No.	Work Phone No.	Cellular Phone No.
Father			
Mother			
Guardian			

First & Last Name of Child	Grade	List Medications	List Allergies

Please identify any specific health problems, medical instructions/special circumstances that you believe are important to know in connection with Religious Education events and activities:

EMERGENCY MEDICAL TREATMENT

In the event of an emergency, I hereby give permission to transport my child to a hospital emergency medical or surgical treatment. I wish to be advised prior to any further treatment by the hospital or doctor. In the event of an emergency, if you are unable to reach me at the above numbers, contact:

Name: _____ Relationship: _____ Phone: _____

Family Doctor : _____ Phone: _____

Family Health Plan Carrier: _____ Policy # _____

I/we, the parent(s)/guardian(s) of the above named student(s):

- Understand that I/we are responsible for notifying St. John Vianney Parish of any changes in the information provided above;
- Authorize any treatment by any licensed medical personnel deemed necessary in the event of a medical emergency and agree to pay for such medical expenses;
- Understand that all reasonable safety precautions will be taken at all times by St. John Vianney Parish;
- Release and hold harmless St. John Vianney Parish, the Roman Catholic Diocese of Honolulu, its employees, agents, contractors or volunteers, from any liability for injury or any damages resulting from participation in any activity/event sponsored by the St. John Vianney Religious Education Program;
- Understand that submission of this form is required for participation in the St. John Vianney Religious Education Program.

Mother/Guardian's Signature

Effective Date

Father/Guardian's Signature

Effective Date