

St. Louis Catholic School
5192 Shady Grove Road
Memphis, TN 38117
901-682-9692

In case of **medical** or **surgical emergency**, I hereby give permission to the physician selected by St. Louis Catholic School, or the physician's representative, to hospitalize and/or secure proper medical treatment for my child named below. I understand that I am responsible for the cost of any medical treatments (including surgery) received by my child. I hereby release the directors and staff of this school from all responsibility for sickness or accidents which occur during the event. **I understand that I will be contacted immediately in the case of an emergency.**

Student Name _____

Date of Birth _____

Parent/Guardian Name _____

Parent/Guardian Signature _____

Home Phone _____ Cell Phone(s) _____

Home Address _____

City/State/Zip _____

Date _____ Insurance Company _____

Insurance Policy # _____ Insurance Certificate # _____

If the situation permits, my first choice of hospital is

*Please understand that depending upon the seriousness of the situation; your child may be transported to the nearest hospital.