Saint Nicholas, Baltimore, MD
GOYA HEALTH PERMISSION FORM

GOYAN'S NAME_____

DATE OF BIRTH_____PHONE # _____

ADDRESS _____

MOTHER'S NAME_____EMPLOYMENT_____cell #_____

FATHER'S NAME_____EMPLOYMENT_____cell # _____

FAMILY DOCTOR'S NAME_____TEL # _____

HOSPITAL OF CHOICE_____

DENTIST'S NAME_____TEL #_____

MEDICAL
PROBLEMS_____

MEDICATIONS ON A REGULAR BASIS _____

KNOWN ALLERGIES_____REACTION_____TREATMENT _____

Names and telephone numbers of two persons to contact if your child is ill or injured.

In the event that the parent or guardian cannot be contacted, these persons and accompanying advisors might have to make a medical decision.

Name_____Telephone _____

Name_____Telephone_____

EMERGENCY MEDICAL TREATMENT
To the Parish Priest and Advisors: In the event that I am unable to be reached and my child needs EMERGENCY MEDICAL TREATMENT during any time he/she is a member of the G.O.Y.A., you have my permission, and I hereby designate you my agent, to act in my son's/daughter's best interest in obtaining necessary transportation and medical care until I can be contacted. I hereby release you from any claim arising out of the doctor's actions, and I assume and agree to pay for any professional medical services incurred.

Date_____Parent/Guardian Signature _____

Permission for emergency medical treatment will be effective throughout the member's enrollment. If there is any change of information, please telephone the parish priest or Advisors.

YOUR INSURANCE COMPANY _____

GROUP IDENTIFICATION #: _____

MEMBER # _____

TELEPHONE # _____

RETURN WITH REGISTRATION FORMS