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 # _____