



# Rosary Cathedral Catholic School



## 2024 -2025 EMERGENCY MEDICAL AUTHORIZATION

PLEASE fill out ONE FORM per student. Please **PRINT** neatly.

NAME: \_\_\_\_\_ D.O.B. \_\_\_\_\_ GRADE \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY/STATE/ZIP: \_\_\_\_\_ PHONE: \_\_\_\_\_

MOTHER'S FULL NAME: \_\_\_\_\_ CELL # \_\_\_\_\_ WORK # \_\_\_\_\_

EMAIL: \_\_\_\_\_

FATHER: NAME \_\_\_\_\_ CELL # \_\_\_\_\_ WORK # \_\_\_\_\_

EMAIL: \_\_\_\_\_

EMERGENCY TELEPHONE NUMBERS WHEN PARENTS ARE NOT AVAILABLE (will be called in order listed after parents/guardians):

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE # \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE # \_\_\_\_\_

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_ PHONE # \_\_\_\_\_

FACTS CONCERNING YOUR CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES, MEDICINES BEING TAKEN, OR PHYSICAL LIMITATIONS THAT THE SCHOOL NURSE SHOULD BE AWARE OF:

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**\*\*Any medications taken at school MUST have a completed form on file signed by your physician. \*\***  
**\*\*Please pick up in the office\*\***

Please complete **EITHER** Part I OR Part II:

### **PART I: TO GRANT CONSENT**

I HEREBY GIVE CONSENT FOR THE FOLLOWING MEDICAL CARE PROVIDERS AND LOCAL HOSPITALS TO BE CALLED:

PHYSICIAN: \_\_\_\_\_ PHONE: \_\_\_\_\_

DENTIST: \_\_\_\_\_ PHONE: \_\_\_\_\_

MEDICAL SPECIALIST (IF APPLICABLE): \_\_\_\_\_ PHONE: \_\_\_\_\_

HOSPITAL: \_\_\_\_\_ PHONE: \_\_\_\_\_

IN THE EVENT REASONABLE ATTEMPTS TO CONTACT ME HAVE BEEN UNSUCCESSFUL, I HEREBY GIVE MY CONSENT FOR (1) THE ADMINISTRATION OF ANY TREATMENT DEEMED NECESSARY BY ABOVE NAMED DOCTORS, OR, IN THE EVENT THE DESIGNATED PREFERRED PRACTITIONER IS NOT AVAILABLE, BY ANOTHER LICENSED PHYSICIAN OR DENTIST; AND (2) THE TRANSFER OF THE CHILD TO ANY HOSPITAL REASONABLY ACCESSIBLE. THIS AUTHORIZATION DOES NOT COVER MAJOR SURGERY UNLESS THE MEDICAL OPINIONS OF TWO OTHER LICENSED PHYSICIANS OR DENTISTS, CONCURRING IN THE NECESSITY FOR SUCH SURGERY, ARE OBTAINED PRIOR TO THE PERFORMANCE OF SUCH SURGERY.

DATE: \_\_\_\_\_ SIGNATURE OF PARENT OR GUARDIAN: \_\_\_\_\_

### **PART II: REFUSAL TO CONSENT**

**I DO NOT** GIVE MY CONSENT FOR EMERGENCY MEDICAL TREATMENT OF MY CHILD. IN THE EVENT OF ILLNESS OR INJURY REQUIRING EMERGENCY TREATMENT, I WISH THE SCHOOL AUTHORITIES TO TAKE THE FOLLOWING ACTION:

DATE: \_\_\_\_\_ SIGNATURE OF PARENT OR GUARDIAN: \_\_\_\_\_