

EMERGENCY MEDICAL AUTHORIZATION

School: Saint Joseph School

Date _____

Student Name _____

Address _____

City, State, Zip _____

Home Phone _____

Grade _____

Purpose- To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian

Mother's Name _____
First Last

Daytime Phone _____

Father's Name _____
First Last

Daytime Phone _____

Other's Name _____
First Last

Daytime Phone _____

Name of Relative or Childcare Provider

Relationship _____

Address _____

Daytime Phone _____

City, St, Zip _____

PART 1 OR 2 MUST BE COMPLETED

PART 1: TO GRANT CONSENT

Part 1 Consent Given Part 2 Consent Refused

Physician _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ ER 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-names doctors, or, in the event the designated preferred practitioner is not available, by any other 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.

Facts concerning the child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

Parent Signature _____

Address _____

City, State, Zip _____ Date _____

PART 2: 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:

Parent Signature _____

Address _____

City, State, Zip _____ Date _____

Please list anyone else who can be called and who has your permission to pick up your child/children in case of illness.

WE WILL CALL IN THE ORDER LISTED BELOW

NAME-RELATION	HOME PHONE NUMBER	CELL PHONE NUMBER
1.		
2.		
3.		
4.		
5.		