CATHOLIC SCHOOLS

EMERGENCY MEDICAL AUTHORIZATION FORM

Purpose: Enables parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached. This Emergency Medical Authorization, must be on file for each student.

PLEASE PRINT AND RETURN TO SCHOOL WITHIN 5 days.

Please Print

Student's Name:_____School:_____Grade:_____

Student's Address:_____

Date of Birth:_____Student ID:_____Teacher:_____

Parent/Guardian's Name:_____Relation to Student:_____

Home Phone:_____Cell:_____Work:_____

Email address:_____

Parent/Guardian's Name:_____Relation to Student:_____

Home Phone:_____Cell:_____Work:_____

Email address:_____

List a person who may be notified and to whom your child may be released if the school cannot reach you:

Name / Relationship / Home Phone / Cell Phone / Work Phone

_____

_____

_____

Facts concerning the child's medical history including allergies, medications, and any physical impairment to which a physician should be alerted._____

Doctor to be called:_____Phone:_____

Dentist to be called:_____ _Phone:_____

Preferred Local Hospital:_____

I give permission for my child to take Ibuprofen: Yes _____ Dosage_____ No _____

I give permission for my child to take Acetaminophen: Yes _____ Dosage_____ No _____

EMERGENCY MEDICAL AUTHORIZATION FORM CONTINUED FROM PAGE 1

Part 1 – TO GRANT CONSENT

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 the above-named doctor or, in the event the designated preferred physician 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 opinion 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/guardian_____

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.

_____

_____

_____

_____

Date:_____ Signature of Parent/guardian_____