EMERGENCY MEDICAL AUTHORIZATION
St. Mary's Catholic School – Berea, OH

PLEASE PRINT CLEARLY

STUDENT NAME: _____ Grade _____

ADDRESS: _____CITY _____ ZIP _____

HOME TELEPHONE: _____ DATE OF BIRTH: _____/_____/_____

Residential Parent or Guardian

Mother living with family? ☐ Yes ☐ No Father living with family? ☐ Yes ☐ No

MOTHER'S NAME: _____ DAYTIME PHONE: _____

FATHER'S NAME: _____DAYTIME PHONE: _____

OTHER NAME _____ DAYTIME PHONE: _____

ADDRESS: _____ RELATIONSHIP: _____

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.

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

DOCTOR: _____ TELEPHONE: _____

DENTIST: _____ TELEPHONE: _____

SPECIALIST: _____TELEPHONE: _____

LOCAL HOSPITAL: _____TELEPHONE: _____

In the event reasonable attempts to contact me at (_____)_____ or (_____)_____ have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____(preferred doctor) or Dr. _____ (preferred dentist), 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 _____ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the surgery is performed.

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

_____

_____

_____ _____ _____

Date Signature of Parent/Legal Guardian Address

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 no action or to:

_____

_____ _____ _____

Date Signature of Parent/Legal Guardian Address