St. Mary Catholic School

MEDICAL AUTHORIZATION

Student Name _____ Homeroom # _____ Date of Birth ____/____/_____

Address _____ Telephone (____)_____

City _____ Zip _____

Purpose--To enable parents/ 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/ Guardian:

Mother's Name_____ Day Phone (____)_____Cell (_____)_____

Email _____

Father's Name_____ Day Phone (____)_____Cell (_____)_____

Email _____

Other's Name _____ Day Phone (_____)_____Cell (_____)_____

Email _____

Name of Relative/ Childcare Provider:

Name_____ Relationship_____ Day Phone (_____)_____

Address_____ City_____ Zip_____

Residential Parent/ Guardian:

Mother living with family? ___Yes ___No Father living with family? ___Yes ___No

My child may be released to: _____

Do not release my child to: _____

PART I OR 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:

Physician _____ Phone (_____)_____

Dentist _____Phone (_____)_____

Medical Specialist _____Phone (_____)_____

Local Hospital _____ Emergency Room Phone (_____)_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) Administration of any treatment deemed necessary by above-names doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) 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:

_____

Signature of Parent/Guardian _____ Date _____

PART II: REFUSAL TO CONSENT - *DO NOT COMPLETE PART II IF YOU COMPLETED PART I*

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:

_____

Signature of Parent/Guardian _____ Date _____