PRIMARY EMAIL _____

St. Mary Catholic School

MEDICAL AUTHORIZATION

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.

Student _____ Grade Level _____ Date of Birth ___/___/____

Address _____ City _____ Zip _____

Residential Parent/ Guardian:

Mother's Name _____ Day Phone (_____) _____

Email _____ Cell (_____) _____

Father's Name _____ Day Phone (_____) _____

Email _____ Cell (_____) _____

Guardian's Name _____ Day Phone (_____) _____

Email _____ Cell (_____) _____

Residential Parent/ Guardian: *Mother living with family?* ☐Yes ☐No *Father living with family?* ☐Yes ☐No

Relative/ Child Care Provider:

Name _____ Relationship _____ Phone (____) _____

Authorization of release: _____

(Clearly print all individuals the child may leave with: Use back of form, if needed)

No authorization of release: _____

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 _____ 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: _____

_____

Parent/ Guardian Signature _____ 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: _____