

EMERGENCY MEDICAL AUTHORIZATION

St. Mary Religious Education Program

FAMILY NAME _____

CHILDREN'S FIRST NAMES _____

HOME ADDRESS _____ PHONE _____

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 II must be completed)

PART I: TO GRANT CONSENT

In the event that reasonable attempts to contact _____ at (h) _____ or (w) _____ or _____ (*other parent or guardian*) at (h) _____ or (w) _____ have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by Dr. _____ (*physician*) phone # _____ or Dr. _____ (*dentist*) phone # _____, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist and 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 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: _____

DATE _____ SIGNATURE _____
(Parent or Guardian)

PART II: REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment to 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 _____
(Parent or Guardian)