EMERGENCY MEDICAL AUTHORIZATION FORM

School: **St. Wendelin Catholic School**

Student: ________________________________

Date of Birth:______________________________

Address: ________________________________

Grade: _____________

City: ____________________Zip: _______

Home 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.

Mother's Name ____________________________

Daytime phone: __________________________

Cell phone: _____________________________

Father's Name ____________________________

Daytime phone: __________________________

Cell phone: _____________________________

Other's Name: ____________________________

Daytime phone: __________________________

Name of relative or child care provider: ____

Address: __________________________________ City: ____________________ Zip: _______

Daytime phone: _____________________________ Cell phone:______________________________

Relationship: _______________________________

PART I OR PART II MUST BE COMPLETED

(SEE REVERSE SIDE)

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) the administration of any treatment deemed necessary by the above-named doctors, or in the event the preferred practitioner 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.

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

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Signature of Parent/ Guardian: ____ Date: ______________

Address: ____City: ______________________Zip: _________

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 the following action:

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Signature of Parent/ Guardian: ____ Date: ______________

Address: ____City: ______________________Zip: _________