

**HOLY FAMILY SCHOOL
2010-2011 EMERGENCY MEDICAL AUTHORIZATION**

PLEASE PRINT

Student Name: _____ Date of Birth _____

LAST

FIRST

Address: _____ Home Telephone(_____) _____

City _____ Zip _____ Room# _____ Teacher _____

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.

Residential Parent or Guardian

Mother living with family? Yes No

Father living with family? Yes No

Mother's Name _____ Daytime Phone (_____) _____
FIRST LAST Cell Phone (_____) _____

Father's Name _____ Daytime Phone (_____) _____
FIRST LAST Cell Phone (_____) _____

Other's Name _____ Daytime Phone (_____) _____
FIRST LAST Cell Phone (_____) _____

***Please provide us with a name of a local relative, friend or childcare provider to contact if a parent cannot be reached:**

_____ Relationship _____

Address: _____ Daytime Phone (_____) _____

_____ Zip _____ Cell Phone (_____) _____

PLEASE COMPLETE OTHER SIDE **→**

PART 1 OR 2 MUST BE COMPLETED

PART 1 – 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 above-named doctors, 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 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 2 - 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:

Signature of _____
Parent/Guardian _____ Date _____