Please complete a separate form for each student

EMERGENCY MEDICAL AUTHORIZATION FORM
ST. JOSEPH SCHOOL

Student's Name:_____ **Grade:**_____ **Birthdate:**_____
Last **First** **Middle**

Address:_____

City:_____ **State:**_____ **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:

Name:_____ **Employer:**_____

Address:_____ **Work Address:**_____

City:_____ **State:**____ **Zip:**_____ **City:**_____ **State:**_____ **Zip:**_____

Home Phone:_____ **Work Phone:**_____ **Ext:**_____

Cell Phone:_____ **Email Address:**_____

FATHER:

Name:_____ **Employer:**_____

Address:_____ **Work Address:** _____

City:_____ **State:**____ **Zip:**_____ **City:**_____ **State:** _____ **Zip:**_____

Home Phone:_____ **Work Phone:** _____ **Ext.:** _____

Cell Phone:_____ **Email Address:**_____

PLEASE COMPLETE SECOND PAGE

PART I OR II MUST BE COMPLETED AND SIGNED

PART I - TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called in the event of an emergency:

Student's Doctor:_____ **Phone:**_____

Dentist:_____ **Phone:**_____

Local Hospital:_____ **ER Phone:**_____

Insurance:_____

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 practitioners, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and 2) the transfer of this 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 this child's medical history (allergies, diseases, disorders, health conditions, medications being taken, physical impairments, etc.) to which a physician should be alerted:

Allergies:_____

Medications:_____

Diseases, health conditions, physical impairments:_____

Other pertinent medical information regarding this child:_____

_____

Signature of Parent/Guardian_____ **Date**_____

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:_____

_____

_____

_____

Signature of Parent/Guardian_____ **Date**_____