EMERGENCY MEDICAL AUTHORIZATION FORM

Parish ______________________________

Student Name _______________________

Address ____________________________

__________________ Zip_______

Telephone___________________________

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's Name___________________________________ Daytime Phone____________________
First Last

Father's Name___________________________________ Daytime Phone ____________________
First Last

Other's Name____________________________________ Daytime Phone____________________

Name of relative or Childcare Provider:

____ Relationship______________________

Address ____ Daytime Phone____________________

______________________________Zip_______________

PART I OR II MUST BE COMPLETED
(See reverse side)

PART I: TO GRANT CONSENT (The separate authorization to Administer Medication or Carry Inhaler form must be completed if applicable.)

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_______________________________ Emergency Room 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 (1) 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:

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Date___________ Signature of Parent/Guardian_________________________________

Address____

__________________________________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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Date____________ Signature of Parent/Guardian________________________________

Address____

__________________________________ Zip____________