

2003-2004 EMERGENCY MEDICAL AUTHORIZATION FORM

School : St . Wendelin Grade School Student _____
Date of Birth: _____ Address _____
Grade/Teacher (2T; 7S etc.) City _____ Zip _____
_____ Home 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 () _____
Father's Name _____ Daytime phone () _____
Other's Name _____ Daytime phone () _____

Name of relative or Child Care Provider

_____ Relationship _____
Address _____ Daytime phone () _____
City _____ Zip _____

PART I OR II MUST BE COMPLETED

(SEE REVERSE SIDE)

DUE BACK TO SCHOOL NO LATER THAN AUGUST 29, 2003

Please return as soon as possible

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 _____ Emergency room phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) for 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:

Date _____ Signature of Parent/Guardian _____

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:

Date _____ Signature of Parent/Guardian _____

Address _____

City _____ Zip _____