

ST. PETER SCHOOL EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents/guardians to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Please PRINT.

Student: _____
Last First

Person to contact/parent not available:

Name: _____

Parent/Guardian Name: _____
Father Mother

Phone: _____

Relationship: _____

Address: _____

Mother's work # _____

Cell Phone # _____

City: _____ Home Phone # _____

Father's work # _____

Cell Phone # _____

Zip: _____

E-Mail _____

PART I - GRANT CONSENT, OR PART II - REFUSAL TO CONSENT, MUST BE COMPLETED

IT IS THE PARENT'S RESPONSIBILITY TO NOTIFY THE SCHOOL OF ANY CHANGE OF INFORMATION.

PART I - (TO GRANT CONSENT)

In the event reasonable attempts to contact me at _____(phone) or other parent at _____ have been unsuccessful, I hereby give my consent for: 1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____(preferred dentist) 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 _____(preferred hospital) or 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 is obtained before surgery is performed. 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: _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 no action or to:

Date: _____ Signature of Parent/Guardian: _____
Address: _____