St. Angela Merici Parish

20970 Lorain Rd.
Fairview Park, Ohio 44126

Emergency Medical Authorization

Complete one form per student.

Student name:_______________________________________ Date_________________________

Street Address_______________________________________ Birthdate ______________________

City and zip code____________________________________ Home telephone ____ ____ _______

PURPOSE: This information will assist the parish in reaching the parents and authorized caregivers of students who attend our Parish School of Religion Program enabling parents to authorize the emergency treatment for the children who become ill or injured while under parish authority.

Custodial parent or guardian:

Please be sure to provide first and last name of all contacts and include area codes with all phone numbers.

Mother____ Work phone____________________

Cell phone______________________

Spouse____ Work phone____________________

Cell phone______________________

Father____ Work phone____________________

Cell phone______________________

Spouse____ Work phone____________________

Cell phone______________________

Please provide the names of two other relatives or child care providers who will be responsible if a parent cannot be reached in the case of an emergency.

Name____ Relationship____________________

Street address_______________________________________ Daytime phone __________________

City and zip code____________________________________

Name____ Relationship____________________

Street address_______________________________________ Daytime phone __________________

City and zip code____________________________________

OVER

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be contacted:

Physician____ Telephone #_______________________

Dentist____ Telephone #_______________________

Medical specialist____ Telephone #_______________________

Local hospital____ Telephone #_______________________

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 doctors or in the event the designated 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 (2) other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of said surgery.

In the following space, please write any 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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Signature of parent____ Date_______________________

Street address____

City and zip code____

PART II – REFUSAL OF CONSENT

I DO NOT grant my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I allow the school authorities permission to take the following action:

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Signature of parent____ Date_______________________

Street address____

City and zip code____