

EMERGENCY MEDICAL AUTHORIZATION

St. Angela Merici Parish
Sunday School

Student Name _____

Address _____

Phone _____ Birth date _____

Purpose -- To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under parish authority, when parents or guardians cannot be reached.

In the event reasonable attempts to contact me at _____ (phone number) or _____ (other parent or guardian) at _____ (phone number) 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.

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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:

Date

Signature of Parent or Guardian

Address

REFUSAL TO CONSENT DO NOT COMPLETE, IF YOU COMPLETED PART I

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 or Guardian

Address