HOLY FAMILY SCHOOL **EMERGENCY MEDICAL AUTHORIZATION** **2016 -2017 School Year**

Student's Last Name	First Name	Birthdate	Grade	Room No.

Home Address	City	Zip Code	Home Phone ( )

Residential Parent or Guardian

Mother living with family? Yes _____ No _____ Father living with family? Yes _____ No _____

Mother	Daytime Tel.	Cell No.
Mother's Occupation:	Company Name:	
Father	Daytime Tel.	Cell No.
Father's Occupation:	Company Name:	
Other Name	Daytime Tel.	Cell No.

PURPOSE: To enable parents to authorize the emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.

Name of Relative or Childcare Provider:	Relationship:	Daytime Tel
1		( )
1 Address:		
2		( )
2 Address:		

PART I OR PART II MUST BE COMPLETED

PART I (TO GRANT CONSENT)

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

Doctor _____ Tel _____

Dentist _____ Tel _____

Medical Specialist _____ Tel _____

Local Hospital _____ Tel _____

In the event reasonable attempts to contact me at _____ (tel #) or _____ (other parent) at _____ (tel #) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred doctor) 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 opinions of 2 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the 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 Address

DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

PART II (REFUSAL OF 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 Address