

# EMERGENCY MEDICAL AUTHORIZATION

**NOTE:** Please notify the office if any of this information changes during the school year.

School Academy of St. Adalbert Student Name \_\_\_\_\_  
Grade Level \_\_\_\_\_ Address \_\_\_\_\_  
Home Phone \_\_\_\_\_

Residential Parent or Guardian: Mother living with family?  Yes  No Father living with family?  Yes  No

Mother \_\_\_\_\_ Father \_\_\_\_\_  
Day Phone \_\_\_\_\_ Day Phone \_\_\_\_\_  
Cell \_\_\_\_\_ Cell \_\_\_\_\_  
Address (If different.) \_\_\_\_\_ Address (If different.) \_\_\_\_\_

Other Contact \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Day Phone \_\_\_\_\_

**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.

## 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 \_\_\_\_\_ Telephone \_\_\_\_\_  
Dentist \_\_\_\_\_ Telephone \_\_\_\_\_  
Medical Specialist \_\_\_\_\_ Telephone \_\_\_\_\_  
Local Hospital \_\_\_\_\_ Telephone \_\_\_\_\_

In the event reasonable attempts to contact me at \_\_\_\_\_ (phone number) or \_\_\_\_\_ (other parent) at \_\_\_\_\_ (phone number) 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