



Parish School of Religion
 Saint Mary of the Assumption
 132 South High Street
 Lancaster, Ohio 43130
www.stmarylancaster.org

Emergency Authorization Form
 2009-2010

Student's Name: _____ Grade: _____

EMERGENCY MEDICAL AUTHORIZATION

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

Please indicate who should be called first:

Mother's Name: _____ Father's Name : _____
 Pager #: _____ Pager #: _____
 Cell Phone : _____ Cell Phone : _____

Emergency Contact if unable to reach parent:

Name: _____
 Relationship: _____
 Phone #: home _____ Cell: _____

Family Physician Name: _____
 Phone Number: _____

Family Dentist Name: _____
 Phone Number: _____

Preferred Hospital : _____

PART I: TO GRANT CONSENT

I hereby give consent for (1) the administration of any treatment deemed necessary by above-named doctors, 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 any hospital reasonably accessible.

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 the performance of such surgery.

Facts concerning the child's medical history, including allergies, medications taken, and any physical impairments to which a physician should be alerted:

Parent Signature _____

Date _____

PART II—TO REFUSE CONSENT:

I **DO NOT** give consent for the emergency medical treatment of my child. In the event of illness or emergency treatment being required, I wish the school authorities to take no action or to: _____

Parent Signature _____

Date _____