ST. MARY SCHOOL – year: _____
School Health Services/Emergency Medical Authorization

Student Name: _____ Grade _____

Address: _____ Phone _____

Purpose – To enable parents to authorize 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 Request

In the event reasonable attempts to contact me at _____ or _____

or _____ at _____ or _____
other parent
have been unsuccessful, I hereby give my consent for the administration of any treatment deem necessary by:

Physican: _____ Phone: _____

Dentist: _____ Phone: _____

Or in the event the designated preferred practitioner is not available, by another licensed physician or dentist. And the transfer of the child to:
Preferred hospital: _____ Phone: _____
or 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 before 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:

_____

_____

Signature of Parent/Guardian _____ Date _____

Address _____

Part II - Refusal to Consent (DO NOT complete part II 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:

_____

_____

Signature of Parent/Guardian _____ Date _____

Address _____
_____

Part III - IMPORTANT: Be sure to complete this section. I understand that medication will not be administered to my child/children unless the "Request for the Administration of Medication by School Personnel" is completed and filed in the school office.

Signature of Parent/Guardian _____ Date _____