Appendix D

Lial Catholic School
Emergency Medical Authorization Form
CYO and School

20___ - 20 ___ school year

Student Name_____ Date of Birth _____

Address _____ City _____ State _____ Zip_____

Primary Emergency Phone _____ Secondary Emergency Phone _____

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

FORM MUST BE SIGNED AND DATED IN INK EACH YEAR

Residential Parent or Guardian:

Mother's Name_____ Daytime Phone_____

Father's Name_____ Daytime Phone_____

Guardian's Name_____ Daytime Phone_____

Person to contact if Parent cannot be reached: (REQUIRED)

Name_____ Phone _____ Relationship_____

Name_____ Phone _____ Relationship_____

Allergies _____ Date of last tetanus shot_____

Medication being taken _____

(Name) (Dosage) (Times Taken)

(continue on back if necessary)

List of health problems. Example: asthma, vision, epilepsy, diabetes, hearing, bone, or muscle problem, etc.:

_____

_____

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

If unable to reach parent or guardian, I hereby give consent for the following medical care providers and local hospital to be called:

Physician_____Phone_____

Dentist_____Phone_____

Medical Specialist_____Phone_____

Preferred Hospital_____ Emergency Room Phone_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my 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 to the performance of such surgery.

*Facts concerning the child's medical history including **date of last tetanus shot, allergies, medications being taken, and any physical impairments to which a physician should be alerted.**

Signature of Parent/Guardian_____

Address_____ Date_____

PART II: REFUSAL TO 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 the following action: **(continue on back if necessary)**

_____

_____

Signature of Parent/Guardian_____

Address_____ Date_____