EMERGENCY MEDICAL AUTHORIZATION FORM
SAINT ROSE SCHOOL

Student Name_____ Grade_____Room_____

Address_____
Street City ZIP

Telephone_____

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

Residential Parent or Guardian

Mother's Name_____
First Last

Phone_____
Daytime Phone Cell Phone

Father's Name_____
First Last

Phone_____
Daytime Phone Cell Phone

Other's Name_____
First Last

Phone_____
Daytime Phone Cell Phone

Name of Relative or Childcare Provider

_____Relationship _____

Address_____
Street City ZIP

Telephone_____
Daytime Phone Cell Phone

(OVER)

PART I: TO GRANT CONSENT

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

Physician_____ Phone_____

Address_____
Street City/State Zip

Dentist_____ Phone_____

Address_____
Street City/State Zip

Medical Specialist_____ Phone_____

Local Hospital_____ Emergency Rm. Ph._____

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 allergies, medications being taken, and any physical impairments to which the physician should be alerted:_____

_____

Date_____ Signature of Parent/Guardian_____

Address_____

_____ Zip_____

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:

_____

_____

Date_____ Signature of Parent/Guardian_____

Address_____

_____ Zip_____

_____YES _____NO CONSENT TO SHARE INFORMATION: The school nurse has permission to share information provided in this report with appropriate members of the educational team for use in meeting the health and educational needs of the student. This will be done only on a "need to know" basis, in a confidential manner. This would include permission for communication between the health provider and school nurse to facilitate this process.

Parent Signature_____ Date_____