SAINT BRIGID OF KILDARE
SKI CLUB

EMERGENCY MEDICAL AUTHORIZATION

Student's Name _____
Home Phone Number w/ Area Code _____

Cell Phone Number w. Area Code _____

Purpose: to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while participating with the SAINT BRIGID OF KILDARE SKI CLUB when parents or guardians cannot be reached. This authorization does not cover major surgery unless medical options of two other licensed physicians or dentists, concurring in the necessity for 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 impairment to which a physician should be alerted:
_____
_____
_____

Part 1-To Grant Consent (Part 1 or 2 must be completed)
In the event reasonable attempts to contact me at _____(phone number) or _____ (phone number) have been unsuccessful, I hereby give my consent for: (1) the administration deemed necessary by Dr. _____ (preferred physician) at _____ (phone number) or by Dr. _____ (preferred dentist) at _____ (phone number) or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist, (2) the transfer of the child to _____ (preferred hospital) or another hospital or any emergency treatment center reasonably accessible.

Signature of Parent/Guardian _____ Date _____

Part 2-Refusal to Consent (Do not complete Part 2 if you completed Part 1)

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish SAINT BRIGID OF KILDARE SKI CLUB authorities to take no action or
to:_____
_____
_____

Address: _____
Signature of Parent/Guardian _____ Date: _____