HOLY FAMILY SCHOOL – Extended Hours
2019-2020 EMERGENCY MEDICAL AUTHORIZATION

PLEASE PRINT

Student Name:____ **Date of Birth**__________
LAST **FIRST**

Address:____ **Home Telephone**(______)____________

City__________________________**Zip** __________ **Room#**__________**Teacher**________________

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

Residential Parent or Guardian Mother living with family? ☐ Yes ☐ No Father living with family? ☐Yes ☐ No

Mother's Name______________________________________Work Phone (_____)_______________
FIRST LAST Cell Phone (_____)_______________

Father's Name______________________________________Work Phone (_____)_______________
FIRST LAST Cell Phone (_____)_______________

Other's Name______________________________________Daytime Phone (_____)_______________
FIRST LAST (RELATION) Cell Phone (_____)_______________

***Please provide us with a name of a <u>local</u> relative, friend or childcare provider to contact if a parent cannot be reached:**

____Relationship_______________________

Address:____________________________________ Daytime Phone (_____)_______________

______________________________Zip________ Cell Phone (_____)_______________

PLEASE COMPLETE OTHER SIDE

PART 1 OR 2 MUST BE COMPLETED

PART 1 – TO GRANT CONSENT

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

Physician____Phone (_____)___________________________________

Dentist____Phone (_____)___________________________________

Medical Specialist____Phone (_____)___________________________________

Local Hospital____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 ALLERGIES, MEDICATIONS BEING TAKEN, AND ANY PHYSICAL IMPAIRMENTS TO WHICH A PHYSICAN SHOULD BE ALERTED:

____

____

Signature of
Parent/Guardian____Date______________________

PART 2 - 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:

____

____

Signature of
Parent/Guardian____Date______________________