EMERGENCY MEDICAL AUTHORIZATION FOR ST. HILARY SCHOOL

Student Name_____ Grade _____ Homeroom _____
Address_____ Birthdate ___/___/___
Tel_____

Parent or Guardian: Mother living with family? ❒ Yes ❒ No Father living with family? ❒ Yes ❒ No

Mother_____ Phone# (BEST number to be reached)_____Alternate #_____
Email Address_____
Father_____ Phone# (BEST number to be reached)_____Alternate #_____
Email Address_____

St. Hilary School requires at least three (3) alternate contacts in case parents cannot be reached. Please be sure these contacts are available during the day to pick your child up from school (after repeated efforts have been made to contact you –including leaving messages):

Name of Alternate Contact _____ Relationship _____
Phone# (BEST number to be reached)_____ Alternate #_____
Name of Alternate Contact _____ Relationship _____
Phone# (BEST number to be reached)_____ Alternate #_____
Name of Alternate Contact _____ Relationship _____
Phone# (BEST number to be reached)_____ Alternate #_____

PURPOSE – To enable parents to authorize the 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 Consent)

I hereby give consent for the following medical care providers and local hospital to be called:
Doctor_____ Tel_____
Dentist_____ Tel_____
Medical Specialist_____ Tel_____
Local Hospital_____ Tel_____
In the event reasonable attempts to contact parent/guardian at the above listed phone numbers have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred doctor) or Dr. _____ (preferred dentist), 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 _____ (preferred hospital) or any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before the 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: _____
_____

_____
Date Signature of Parent Address

DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

PART II (Refusal of 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 no action or to:
_____

_____ _____ _ _____
Date Signature of Parent Address