

**St. Joan of Arc PSR**  
**Emergency Medical Authorization**  
**2017-2018**

**Child/ren's Full Names** \_\_\_\_\_  
**Last Name** \_\_\_\_\_ **Home Phone** \_\_\_\_\_

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

**Please indicate with a \*star who should be called first:**

Mother's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Father's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Emergency Contact if unable to reach parent:**

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell \_\_\_\_\_

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Family Physician Name \_\_\_\_\_  
Phone Number \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

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**Part I: TO GRANT CONSENT**

I hereby give 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 licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior the performance of such surgery.

The following are facts concerning the child's medical history, including allergies, medications taken, and any physical impairments to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_

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**Part II: TO REFUSE CONSENT**

I **DO NOT** give consent for the emergency medical treatment of my child. In the event of illness or emergency treatment being required, I wish the authorities to take no action or to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_