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 _____

Family Physician Name _____
Phone Number _____

Preferred Hospital _____

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 _____

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 _____