SAINT BERNADETTE SCHOOL
2018-2019 SCHOOL YEAR
EMERGENCY MEDICAL AUTHORIZATION FORM

Gr. _____ Rm. _____

Student Last Name: _____ **First Name:** _____

Student Address: _____ **Phone:** _____

City & Zip Code: _____ **Date of Birth:** _____

Residential Parent/Guardian:

Mother's Name: _____ **Daytime Phone:** _____
Is Mother living with family? _____Yes _____No
Cell Phone: _____
Work Phone: _____

Father's Name: _____ **Daytime Phone:** _____
Is Father living with family? _____Yes _____No
Cell Phone: _____
Work Phone: _____

Name of person to provide care if parents cannot be reached:

Person's Name: _____ **Daytime Phone:** _____

Relationship: _____ **Cell Phone:** _____
Work Phone: _____

Does your child have any medical conditions or medications we should be aware of? _____

_____

_____

PART I *or* PART II MUST BE COMPLETED *(DO NOT fill out both!)*

PART I – TO GRANT CONSENT I hereby give consent for the following medical care providers and local hospitals to be used:

Physician: _____ **Doctor's Phone:** _____

Dentist: _____ **Dentist's Phone:** _____

Hospital: _____ **Hospital's Phone:** _____

Medical Specialist: _____ **Doctor's Phone:** _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment necessary by above named doctors, or, in the event the designated preferred practitioner is not available, by any other 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 dentist, concurring in the necessity for surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history, including allergies, medication being taken, and any physical impairment to which a physician should be alerted.

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

PART II – REFUSAL OF CONSENT

I DO NOT GIVE MY CONSENT FOR EMERGENCY MEDICAL TREATMENT FOR MY CHILD. In the event of illness or injury requiring medical treatment, I wish the school authorities to take the following action:

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