Guardian Angels School Emergency Medical Authorization

2019-2020

Student's Legal Name _____ **Date of Birth** _____

Homeroom Teacher _____

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

PART I OR PART II MUST BE COMPLETED

PART I

In the event reasonable attempts to contact **Primary Family Contact & Emergency Contacts** have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by **Doctor or Dentist listed:**

Dr. _____ **Phone**_____ **(preferred physician)**

Dr. _____ **Phone**_____ **(preferred dentist)**

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.

The 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 physician should be alerted: _____

_____

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

PLEASE RETURN THIS FORM TO THE SCHOOL OFFICE

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II: REFUSAL TO CONSENT

I do not give my consent for emergency medical treatment for my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action or to _____

_____ _____

Parent/Guardian Signature Date