

ST. RITA SCHOOL - Emergency Medical Authorization Form

Student Last Name*	First Name*	Middle Name*	Other Name	Grade Level*	Teacher	School
Date of Birth	Sex (Circle) (M) (F)	Address*			Home Telephone* Unlisted Yes <input type="checkbox"/> No <input type="checkbox"/>	()

YES I want the (*) information published in my student's school directory. NO I do not want the (*) information published.

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

Mother/Guardian: Last Name*	First Name*	Place of Employment	Daytime Telephone ()	Cell Phone ()	Lives with Family (circle) yes no
E-Mail Address					
Father/Guardian: Last Name*	First Name*	Place of Employment	Daytime Telephone ()	Cell Phone ()	Lives with Family (circle) yes no
E-Mail Address					
Other's Name/Guardian: Last Name	First Name	Place of Employment	Daytime Telephone ()	Cell Phone ()	Lives with Family (circle) yes no

If above information is different from last year, please check box.

If cannot be contacted and it is advisable to send my child home due to minor illness or injury, my child can be released in the custody of:

1.	Name of Relative or Childcare Provider	Relationship	Address	Daytime Telephone ()
2.	Name of Relative or Childcare Provider	Relationship	Address	Daytime Telephone ()

Date: _____ SIGNATURE OF PARENT/GUARDIAN: _____

If information in #1 and #2 is different from last year, please check box.

ID# _____
(Office use only) **(OVER)**

Eff.2002/03

(PART I OR 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:

Physician _____ Phone (_____) _____
 Dentist _____ Phone (_____) _____
 Medical Specialist _____ Phone (_____) _____
 Local Hospital _____ Emergency Room Phone (_____) _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my 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 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: _____

Date: _____

SIGNATURE OF PARENT/GUARDIAN _____

(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 of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: _____

Date: _____

SIGNATURE OF PARENT/GUARDIAN: _____