

**St. Gregory the Great 2008-2009 School Year**  
**EMERGENCY MEDICAL AUTHORIZATION**      **Grade \_\_\_\_\_ Room \_\_\_\_\_**

Student Name \_\_\_\_\_ Telephone \_\_\_\_\_

Address \_\_\_\_\_

Residential Parent or Guardian

Mother living with family \_\_\_\_\_ Yes \_\_\_\_\_ No      Father living with family \_\_\_\_\_ Yes \_\_\_\_\_ No

Mother \_\_\_\_\_ Daytime phone \_\_\_\_\_

Father \_\_\_\_\_ Daytime phone \_\_\_\_\_

Other Name \_\_\_\_\_ Daytime phone \_\_\_\_\_

Relative or Childcare Provider \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

**Purpose** – to enable parents to authorize the emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.

**PART I OR PART II MUST BE COMPLETED**

**PART 1 (TO GRANT CONSENT)**

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor \_\_\_\_\_ Telephone \_\_\_\_\_

Dentist \_\_\_\_\_ Telephone \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Telephone \_\_\_\_\_

Local Hospital \_\_\_\_\_ Telephone \_\_\_\_\_

In the event reasonable attempts to contact me at \_\_\_\_\_ (tel) or \_\_\_\_\_ (other parent) at \_\_\_\_\_ (tel) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. \_\_\_\_\_ (preferred doctor) or Dr. \_\_\_\_\_ (preferred dentist), 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 \_\_\_\_\_ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of 2 other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted: \_\_\_\_\_

\_\_\_\_\_

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

**DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I**

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 no action or to: \_\_\_\_\_

\_\_\_\_\_

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