

2009-2010 St.Mary Parish
PARISH SCHOOL OF RELIGION
EMERGENCY MEDICAL AUTHORIZATION

Student Name _____

Address _____

Telephone _____ Cell Phone: _____

Purpose – to enable parents and guardians to authorize the provision of emergency treatment for children whom become ill or injured while under PSR authority, when parents or guardians cannot be reached.

Residential Parent or Guardian:

Mother's Name _____ Phone _____
(First) (Last)

Father's Name _____ Phone _____
(First) (Last)

Name of Relative or Childcare Provider FOR EMERGENCY CONTACT:

_____ Relationship _____

Phone _____

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 _____

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 impairment to which a physician should be alerted:

Date _____ Signature of Parent/Guardian _____

PLEASE COMPLETE AND RETURN WITH REGISTRATION!