St. John Paul II Early Childhood Education Center

Emergency Medical Authorization Form

The purpose of this form is to enable parent(s)/guardian(s) to authorize the provision of emergency treatment for your child who becomes ill or injured while under school authority, when you cannot be reached.

Child's name____

Parent's Name and Cell Phone ____

Address:____

Part 1: To Grant Consent

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

Physician: ____ Phone ___________________________

Dentist: ____ Phone _____________________________

Local Hospital: _____________________________________ Emergency Room Phone _______________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the (1) authorization of any treatment deemed necessary by the 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 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.

List below facts concerning your child's medical history, including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

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Date: ________________________ Signature of Parent/Guardian __________________________________

DO NOT COMPLETE PART 2 IF YOU COMPLETED PART 1

Part 2: Refusal to Consent

I do **NOT** give my consent for emergency medical treatment of my child. In the event of an illness or injury requiring emergency treatment, I wish the school to take the following action:

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Date: ________________________ Signature of Parent/Guardian _________________________________