CATHOLIC DIOCESE OF YOUNGSTOWN
Office of Catholic Schools

EMERGENCY MEDICAL AUTHORIZATION

Student:_____ Class:_____
(Last) (First) (Middle)

Address: _____ Home Phone: _____
(Street, City, State, Zip)

Mother's Name: _____ Work Phone: _____

Father's Name: _____ Work Phone: _____

Cell Phone or Pager Numbers: Father _____ Mother _____

Alternate Persons to Contact: (People to contact if your child is ill and neither parent can be reached)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments or medical condition which the school or an emergency physician should know.

_____

_____

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

Part One or Two Must be Completed

PART ONE: TO GRANT CONSENT

In the event reasonable attempts to contact me at home or at work or other parent or guardian have been unsuccessful, I hereby give my consent for:

1. The administration of any treatment deemed necessary by:

   Dr._____(preferred physician) Phone: _____

   Dr._____(preferred physician) Phone: _____

or, in the event the DESIGNATED preferred practitioner is not available, by another physician or dentist: and

2. The transfer of the child to_____(preferred hospital) Phone: _____

or any other 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. A school official will accompany the child until a parent or guardian can be reached.

Signature of Parent or Guardian: _____ Address:_____Date: _____

Do NOT complete Part Two if you have completed Part One.

PART TWO: 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 school authorities to TAKE NO ACTION OR TO _____

_____

Signature of Parent or Guardian: _____ Address: _____ Date: _____

Please complete both sides of this form.

Child's Name _____ Date of Birth _____

Height _____ Weight _____

CHRONIC PHYSICAL PROBLEM(S):
HISTORY OF HOSPITALIZATION:
DISEASES THIS CHILD HAS HAD:
ALLERGIES AND TREATMENT:
MEDICATIONS, FOOD SUPPLEMENTS, MODIFIED DIET OR FLOURIDE SUPPLEMENTS:

List of person(s) to whom this child can be released: (Please print)

List of person(s) **not permitted** to pick up this child: (Please print)

	Restraint papers or divorce decree attached Yes No

IMPORTANT: Please attach a copy of your child's immunization records

EXEMPT FROM IMMUNIZATIONS	Please mark Yes No
Religious conviction	
Other:	

Parent/Guardian signature for immunization exemption:

_____