School Year 2017-2018

EMERGENCY MEDICAL AUTHORIZATION FORM

Annunciation Catholic School

Student's Last Name: _____ First: _____ Middle Initial:_____
Date of Birth: _____ Gender (circle one): Female Male
Street Address: _____ City: _____
State: _____ Zip: _____ Home Phone: _____

Grade for 2016-17 School Year: _____

PURPOSE To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

☐ Check here if **NO** known allergies of **NO** daily medications.

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

_____
_____
_____
_____
_____

A. Parent or Guardian (Primary Contact)

Primary Contact Name _____ Phone #1 _____
Relationship to Student _____ Phone #2 _____

Secondary Contact Name_____ Phone #1 _____
Relationship to Student _____ Phone #2 _____

Additional Contact Name _____ Phone #1 _____
Relationship to Student _____ Phone #2 _____

Additional Contact Name _____ Phone #1 _____
Relationship to Student _____ Phone #2 _____

B. Names of Relatives or Childcare Providers to call if persons named above cannot be reached.
List up to three people who may make decisions in regard to your child.

Emergency Contact _____ Daytime Phone _____
Relationship to Student _____
Address w/ Zip Code _____

Emergency Contact _____ Daytime Phone _____
Relationship to Student _____
Address w/ Zip Code _____

Emergency Contact _____ Daytime Phone _____
Relationship to Student _____
Address w/ Zip Code _____

CONTINUE ON BACK
PART I OR II MUST BE COMPLETED, SIGNED AND DATED

School Year 2017-2018

PART I TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:
Doctor's Name: _____ Phone: _____
Dentist's Name: _____ 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 doctor, 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 reasonable 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.

Signature of Parent/Guardian _____ **Date** _____

Address of Signatory (If different from student) _____

***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 actions:

_____
_____
_____
_____
_____

Signature of Parent/Guardian _____ **Date** _____

Address of Signatory (If different from student)

_____

THE ADMINISTRATION OF ANNUNCIATION MAY SHARE THIS INFORMATION WITH FACULTY AND STAFF ON A NEED-TO-KNOW BASIS.