BISHOP ROSECRANS HIGH SCHOOL EMERGENCY MEDICAL AUTHORIZATION

STUDENT NAME _____

ADDRESS _____ PHONE _____

PURPOSE: To enable parents to authorize 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 I (TO GRANT CONSENT)

In the event reasonable attempts to contact me at _____ (phone number) or _____ (other parent) at _____(phone number) have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist) or in the event the preferred practitioner is not available by another licensed physician or dentist, and the transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical options of two other licensed physicians or dentists concurring in the necessity for such surgery before the surgery is performed. Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

Allergies _____ Date of last tetanus shot _____

Medication being taken _____

Physical impairments (heart, epilepsy, etc.) _____

Other pertinent facts to which a physician should be alerted: _____

DATE _____WITNESS (other than parent or guardian)_____

SIGNATURE of parent or Guardian _____

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: _____

_____

DATE _____ SIGNATURE of parent or Guardian _____

ADDRESS _____