

# EMERGENCY MEDICAL AUTHORIZATION

St. Angela Merici Parish  
Sunday School

Student Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Birth date \_\_\_\_\_

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

In the event reasonable attempts to contact me at \_\_\_\_\_ (phone number) or \_\_\_\_\_ (other parent or guardian) at \_\_\_\_\_ (phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. \_\_\_\_\_ (preferred physician) or Dr. \_\_\_\_\_ (preferred dentist), 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 \_\_\_\_\_ (preferred hospital) or any hospital reasonably accessible.

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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 impairments to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Address

## REFUSAL TO CONSENT DO NOT COMPLETE, IF YOU COMPLETED PART I

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 no action or to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Address