2010-2011

EMERGENCY MEDICAL AUTHORIZATION

CATHOLIC SCHOOL SERVICES – DIOCESE OF TOLEDO

SCHOOL DISTRICT:
ST. PETER'S HIGH SCHOOL & JR. HIGH
104 WEST FIRST STREET
MANSFIELD, OHIO 44902
(419) 524-0979

STUDENT'S NAME:_____
PARENT'S NAME:_____
HOME PHONE:_____
WORK PHONE:_____
CELL PHONE:_____

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

EITHER PART I OR PART II MUST BE COMPLETED

PART I TO GRANT CONSENT

In the event reasonable attempts to contact me at _____(Phone No.) or _____(other parent or guardian) at _____(Phone No.) have been unsuccessful, I hereby give my consent to the administration for any treatment deemed necessary by Dr._____(preferred physican) or Dr._____ (preferred dentist), or in the event the designated preferred practitioner is not available, by another licensed physican 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 opinions of two other licensed physicians or dentists, concurring on 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 or emotional conditions*** to which a physician or the school should be alerted:

_____

_____

_____ _____ _____
DATE OF LAST TETANUS SHOT SIGNATURE OF PARENT/GUARDIAN DATE

INSURANCE COMPANY_____ **POLICY NO.**_____

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 no action or to:

_____

_____

_____ _____
SIGNATURE OF PARENT/GUARDIAN DATE