EMERGENCY MEDICAL AUTHORIZATION FORM

St. Caspar Religious Education Program

Student's name_____
(first) (middle) (last)

Address_____

Home telephone number_____ Religious education level_____

Purpose of this form: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under religious education program authority when parents or guardians cannot be contacted.

Residential Parent or Guardian

Father's name_____
(first) (last)

Father's home phone if different than student's_____
cell phone_____

Mother's name_____
(first) (last)

Mother's home phone if different than student's_____
cell phone_____

Other's name_____

Other's evening/weekend phone if different than student's_____

Name of Relative or Childcare Provider

_____ Relationship_____

Address_____

Home phone_____ Cell phone_____

If there are medical problems of which we should be aware, please give details below. Thank you.

Part I or II must be completed.
(see reverse side)

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician_____ Phone_____

Dentist_____ 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 the above-named doctors 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 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.

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/guardian_____

Address_____

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 religious education program authorities to take the following action:

_____

_____

Date_____ Signature of parent/guardian_____

Address_____