St. Mary of the Immaculate Conception School

EMERGENCY MEDICAL FORM

________________ School Year

Student name: ____ Grade: ____________

Address: ____ Phone: ___________________

Purpose – To enable parent 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 REQUEST

In event reasonable attempts to contact me at ___________________ or _________________

or ______________________________ at ____________________ or _________________

have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by:

Physician: ____ Phone: ___________________

Dentist: ____ Phone: ___________________

Or, in the event the designated preferred practitioner is not available, by another licensed Physician or dentist. And the transfer of the child to:

Preferred hospital: __________________________________ Phone: ___________________

Or, 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 before surgery is performed.

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

____

____

Signature of Parent/Guardian: ____________________________ Date: ___________________

Address: ____

PART II – REFUSAL TO CONSENT (DO NOT COMPLETE PART II 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:

____

____

Signature of Parent/Guardian: ____________________________ Date: ___________________

Address: ____

PART III – IMPORTANT: BE SURE TO COMPLETE THIS SECTION. I understand that medication will not be administered to my child/children unless the "Request for the Administration of Medical by School Personnel" form is completed and filed in the school office

Signature of Parent/Guardian: ____________________________ Date: ___________________