

St. Bridget Parish Religious Education Program 2011-12
Emergency Medical Authorization

Family (Last Name) _____ Home Phone # _____

Parent/Cell Phone # _____

If you can't be reached either at home or on your cell phone:

Emergency Contact _____ Emergency # _____

<u>Child's Name</u>	<u>Grade</u>	<u>Child's Name</u>	<u>Grade</u>
1. _____	_____	2. _____	_____
3. _____	_____	4. _____	_____

Purpose

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

In the event reasonable attempts to contact me at _____ (phone #) or _____ (other parent or guardian) 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.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, 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

Refusal To Consent

(Do not complete if you completed top portion).

I do not give my consent for emergency medical treatment of my child. In the event of illness or injury, requiring emergency treatment, please do the following: _____

Date: _____
Signature of Parent or Guardian

THIS FORM MUST ACCOMPANY THE STUDENT REGISTRATION FORM.