Please complete for Every Child

LAKEWOOD CATHOLIC ACADEMY
EMERGENCY MEDICAL AUTHORIZATION

_____ School year _____ Grade _____ Homeroom #

Child's Name:_____

Address: _____

Phone: _____

Purpose -- To enable parents 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 the event reasonable attempts to contact me at _____ (phone) or _____ (other parent) at _____ (phone) 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 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 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:_____

_____

_____

_____ Date _____ Signature of Parent _____ Address

****DO NOT COMPLETE PART II IF YOU COMPLETED PART I ****

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: _____

_____

_____ Date _____ Signature of Parent _____ Address