SAINT LOUIS SCHOOL
214 NORTH CHAPEL STREET
LOUISVILLE OH 44641

EMERGENCY MEDICAL AUTHORIZATION

STUDENT_____ GRADE_____
Last First Middle

ADDRESS_____

HOME PHONE ( )_____ CELL (Mother) ( )_____ (Father) ( )_____

ALTERNATE PERSON TO CONTACT_____ (Phone) ( )_____
Name

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

PART I OR II MUST BE COMPLETED

Part I (to grant consent)

In the event reasonable attempts to contact me at home or work 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 physical) or Dr. _____ (preferred dentist) or, in the event the designated preferred practitioner is not available by another licensed physical 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 prior to the performance of such surgery.

DOES YOUR CHILD HAVE ANY UNUSUAL HEALTH CONDITIONS? ☐ Yes ☐ No

IF YES, PLEASE INDICATE:

☐ Asthma
☐ Kidney/Bladder
☐ Arthritis
☐ Diabetes
☐ Bee Sting Allergy

☐ Other Allergy (list):
_____
☐ Mild ☐ Severe
☐ Internal Irregularities
☐ Convulsive Seizures

☐ Sight Impairment
☐ Wears Glasses
☐ Deafness
☐ Surgical
☐ Fractures

☐ Heart
☐ Physical Handicap (Describe):
_____
☐ Other
_____

_____ _____
Signature of Parent or Guardian Date

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 or Guardian Date