ST. VIVIAN SCHOOL **homeroom** _____
EMERGENCY MEDICAL AUTHORIZATION

STUDENT NAME _____
D.O.B. _____
SOCIAL SECURITY NUMBER _____
ADDRESS_____ ZIP _____
HOME PHONE _____

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

Residential Parent or Guardian

Mother's Name _____ Mother's Daytime Phone _____
Cell Phone _____

Father's Name _____ Father's Daytime Phone _____
Cell Phone _____

Other Name _____ Other Daytime Phone _____
Cell Phone _____

Name of Relative or Childcare Provider

Name _____ Relationship _____
Address _____ Phone Number _____
_____ _____

PART I or II MUST BE COMPLETED

Part I – TO GRANT CONSENT

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

Physician's Name _____ Phone _____

Dentist's Name _____ 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 above-named doctor, 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 MMEDICAL HISTORY INCLUDING ALLERGIES, MEDICATIONS BEING TAKEN, AND ANY PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED:

Date:_____ Signature of Parent/Guardian _____
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 the following action:

Date:_____ Signature of Parent/Guardian _____
Address _____