School Health Services
Emergency Medical Authorization
St. Mark School
2017/2018

Student's Last Name_____ Student 's First Name_____

Street Address_____ City, Zip_____ Phone _____

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

PART 1 OR PART 2 MUST BE COMPLETED.

PART 1-TO GRANT REQUEST

In the event reasonable attempts to contact me at _____(Phone) or _____(Other Parent/Guardian)

at_____(Phone) have been unsuccessful, I hereby give my consent for:

(1) Administration of any treatment deemed necessary by

Dr._____(Physician) or Dr._____(Dentist)

or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist:

(2) transfer of my child to _____(Preferred Hospital) or any hospital reasonably assessible.

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 before surgery is performed.

Fact concerning my child's medical history, including allergies, medication being taken, and any physical impairment to which a physician should be alerted:

_____

_____

_____

_____ _____

Signature of Parent/Guardian Date

PART 2 -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:

_____

_____

_____ _____

Signature of Parent/Guardian Date

**********OVER**********