EMERGENCY MEDICAL AUTHORIZATION FORM
2021-22

(Please Print)

Student's Name_____DOB_____Grade_____

Address_____City_____

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

If there is an emergency, make an attempt to contact me:

Name_____Relationship_____

Phone_____Cell Phone_____Other (Phone) _____

If I cannot be reached, please contact:

Name_____Relationship_____

Phone_____Cell Phone_____Other (Phone)_____

List two local adults who will assume temporary care of your child in case of illness or an emergency:

A.

_____

(Name) (City) (Phone)

B.

_____

(Name) (City) (Phone)

HEALTH HISTORY

Please fill in the following so that we may better serve your child and guard his or her health and well-being.

Please list any allergies:_____

_____

_____

Please state any specific medical instructions if your child should have an allergic reaction:

_____

_____

_____

_____

Please list any health related issues of which we should be aware of:

_____

_____

_____

_____

*****PLEASE BE SURE TO COMPLETE THE OTHER SIDE OF THIS FORM*****

GRANT OF CONSENT

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

Physician_____Phone_____

Dentist_____Phone_____

Local Hospital_____Phone_____

Insurance Company_____Policy Number_____Phone_____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by able named doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and the transfer of my 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 my child's medical history, including allergies, medications being taken and any physical impairment to which a dentist or physician should be alerted:

_____

_____

Signature of Parent/Guardian_____Date_____

Address_____City_____

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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 parish OR school authorities to take the following action:

_____

Signature of Parent/Guardian_____Date_____

Address_____City_____Phone_____