BISHOP LEIBOLD SCHOOL
EMERGENCY MEDICAL AUTHORIZATION FORM

STUDENT NAME _____DATE OF BIRTH _____

ADDRESS _____

CITY _____ ZIP_____

TELEPHONE (____)_____ GRADE/HOMEROOM_____

EMAIL ADDRESS _____

_____ PLEASE CHECK IF THE ABOVE DATA IS NEW SINCE REGISTRATION

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.

Residential Parent or Guardian **(**Please indicate whom we should try to reach first**)**

Mother's Name _____ Daytime Phone _(____)_____
(First) (Last) Pager or cell phone _(____)_____

Father's Name _____ Daytime Phone _(____)_____
(First) (Last) Pager or cell phone _(____)_____

Other's Name _____ Daytime Phone
_(____)_____
(First) (Last)

Name of Relative or Childcare Provider

_____ Relationship _____

Address _____ Daytime Phone _(____)_____

_____ Zip _____

PART I OR II MUST BE COMPLETED
(See Reverse Side)

PART 1: TO GRANT CONSENT

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

Physician _____ Phone _(____)_____

Dentist _____ Phone _(____)_____

Medical Specialist _____ Phone _(____)_____

Local Hospital _____ 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 doctors, 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 dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

****Medical Health Information:** Facts concerning the child's medical history to which a physician should be alerted:

allergies: _____

recommended treatment: _____

medications being taken: _____

health conditions: _____

_____

Date _____ Signature of Mother/Guardian _____

Date _____ Signature of Father/Guardian _____

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 Mother/Guardian _____

Date _____ Signature of Father/Guardian _____