EMERGENCY MEDICAL AUTHORIZATION FORM

Gesu Parish Religious Education Program Student Name_____
Address_____
Age _____Phone_____

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
Mother's name_____ phone_____
Father's name_____phone_____
Emergency contact_____phone_____

Name of relative or Childcare Provider
_____Relationship_____
Address_____Phone_____

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_____
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 (1) 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 medical history, **including allergies**, **medications being taken**, and any physical impairments to which a physician should be alerted:

_____
_____.

Date_____ Signature of Parent or Guardian_____
Address_____
_____

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 and Phone_____
_____