SANDUSKY CENTRAL CATHOLIC SCHOOL
EMERGENCY MEDICAL AUTHORIZATION FORM

Grade _______
Student's Name ____ D.O.B. ________________ SSN ___________________
(optional)
Address __________________________City _____________________ Zip ________Phone ______________________

Note: It is the responsibility of parents and guardians to notify the school if changes to this form are to be made.

Parent/Custodial Guardian ____

Mother's Name ____

Mother's home address ____ City ____________________ Phone _______________

Mother's Daytime Phone/Ext. ____ Cell/Pager ____________________________

Workplace ____

Father's Name ____

Father's home address ____ City ____________________ Phone _______________

Father's Daytime Phone/Ext. ____ Cell/Pager ____________________________

Workplace ____

Please list three additional people we might contact if unable to reach parent/guardian.

1. Name_____________________________________ Relationship_________________ Daytime Phone __________________
2. Name_____________________________________ Relationship_________________ Daytime Phone __________________
3. Name_____________________________________ Relationship_________________ Daytime 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.

COMPLETE EITHER PART I OR PART II (ON BACK)

PART I - TO GRANT CONSENT

In the event reasonable attempts to contact me or other parent/guardian have been unsuccessful, I hereby give consent for (1) the administration of any treatment deemed necessary by Dr. ___________________________________ (preferred physician) or by Dr.____________________________________ (preferred dentist) or, in the event the above mentioned physician is not available, by another licensed physician or dentist; and (2) the transfer of the child to Firelands Main Campus North/any hospital within reasonable distance.

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 are:

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Any immunization updates, please include date administered ____
I also grant permission to the school nurse to share medical information with school personnel who have a need to know such details in order to best serve my child.

Date ______________________ Signature of Parent/Guardian __________________________________

OVER

PART II – REFUSAL TO GRANT 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:

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Date _____________________ Signature of Parent/Guardian ______________________________