Holy Angels/St. Anthony Pastoral Region

Emergency Medical Authorization 2017-18 PSR Year

Please fill out one form for each student

Student enrolled in PSR: ____

PURPOSE – To enable parents and guardians to authorize the provisions of emergency treatment for children who become ill or injured while at PSR when parents or guardians cannot be reached.

PART I OR II MUST BE COMPLETED

In the event reasonable attempts to contact me at ______________________ (phone number) or __________________________ (or parent or guardian) at _____________________ (phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _________________________________ (preferred physician and phone number) or Dr. _________________________________ (preferred dentist and phone number), or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of child to ___________________________ (preferred hospital) or 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:

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____.

Date: ______________ Signature of Parent/Guardian: ______________________________________

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II REFUSAL TO CONSENT

I do not give 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: ______________________________________