ST. BRENDAN PARISH SCHOOL OF RELIGION
2012-2013 EMERGENCY MEDICAL AUTHORIZATION FORM
(A separate form must be filled out for each registered child)

Child's Name_____ Phone _____

Address_____ Zip _____

Purpose - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while attending PSR classes when parents or guardians cannot be reached.

RESIDENTIAL PARENT OR GUARDIAN:

Mother _____ Phone_____
First Last

Father _____ Phone_____
First Last

Other _____ Phone_____
First Last

If I cannot be contacted and it is advisable to send my child home due to minor illness or injury, my child can be released to the following:
Name _____ Relationship _____ Phone _____

PART A OR B MUST BE COMPLETED

PART A: TO GRANT CONSENT FOR: CHILD'S NAME: _____

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

Physician _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Emergency Room Phone _____

Medical Insurance Provider _____ No: _____

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:
Dr._____ (preferred doctor), or Dr. _____(preferred dentist) 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 _____(preferred hospital) or any hospital reasonably acessible.

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 /Guardian _____

PART B: REFUSAL TO CONSENT FOR: CHILD'S NAME: _____
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 PSR Administrator to take the following action: _____
_____

Date _____ Signature of Parent/Guardian _____