School Health Services
Emergency Medical Authorization
St. Mark School

Student's Last Name__________________________ Student 's First Name______________________

Street Address____________________________________ City, Zip_______________ Phone ___________

Purpose: To enable parents/guardian to authorize emergency treatment for children who become ill or injured while under school authority, when parents/guardians cannot be reached.

PART 1 OR PART 2 MUST BE COMPLETED.

PART 1-TO GRANT REQUEST

In the event reasonable attempts to contact me at _____________________ or ______________________________
(Phone) (Other Parent/Guardian)

at__________________ have been unsuccessful, I hereby give my consent for:
(Phone)

(1) Administration of any treatment deemed necessary by

Dr.________________________ or Dr.________________________
(Physician) (Dentist)

or, in the event the designated preferred practitioner is not available,
by another licensed physician or dentist:

(2) transfer of my child to __________________________ or any hospital reasonably assessible.
(Preferred Hospital)

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 before surgery is performed.

Fact concerning my child's medical history, including allergies, medication being taken, and any physical impairment to which a physician should be alerted:

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____ _______________
Signature of Parent/Guardian Date

PART 2 –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 no action or to:

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Signature of Parent/Guardian Date

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