

**LITTLE FLOWER CHURCH  
2015-2016 EMERGENCY MEDICAL AUTHORIZATION FORM**

Purpose – to enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school/parish authority when parents or guardians cannot be reached.



Student Name \_\_\_\_\_

Student Address \_\_\_\_\_

Street City Zip

Telephone \_\_\_\_\_

**FIRST CONTACT**

Residential Parent or Guardian

Mother's Name \_\_\_\_\_

Day Phone \_\_\_\_\_

First Last

Father's Name \_\_\_\_\_

Day Phone \_\_\_\_\_

First Last

Guardian Name & Relationship \_\_\_\_\_

Guardian Day Phone \_\_\_\_\_

SECOND CONTACT

Name \_\_\_\_\_

Day Phone \_\_\_\_\_

Relationship \_\_\_\_\_

Does your child have a physical or medical condition or allergies that his/her teacher should be aware of?  
(Y/N) \_\_\_\_\_ Please explain \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is your child on any medication we should be aware of? (Y/N) \_\_\_\_\_ Please list \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Any additional comments? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PART I: 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 \_\_\_\_\_

Local Hospital \_\_\_\_\_

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 (2) 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 impairment to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
Street City Zip

**PART II: 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:

\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_  
Street City Zip

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