Emergency Medical Authorization Form (Please print)

Student Name: ____

Birthdate: ____

Address:____

Mother's or Guardian Full Name:____ Phone: _________________

Father's or Guardian Full Name: ____ Phone:_________________

IN THE EVENT EMERGENCY TREATMENT IS NEEDED, I GIVE THE HOSPITAL, ITS AUTHORIZED PERSONNEL AND/OR PHYSICIAN PERMISSION TO TREAT MY SON /DAUGHTER AS NECESSARY.

Signed: ____ Date: _______________________________

Physician: ____Phone: ______________________________

Dentist: ____________________Hospital Preference: ____

OR

I DO NOT GIVE MY CONSENT FOR EMERGENCY MEDICAL TREATMENT OF MY CHILD. IN THE EVENT OF ILLNESS OR INJURY REQUIRING MEDICAL TREATMENT, I WISH THE PARISH AUTHORITIES TO TAKE NO ACTION OR TO:

____

____

Signed: ____ Date: ___________________________

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IF PARENT CANNOT BE REACHED, PLEASE CALL:

First Contact's Name: ____Phone: ________________

Second Contact's Name: ____Phone:________________

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IMPORTANT MEDICAL INFORMATION

Allergies:____

____

Taking Medications: ____

Reason: ____

Original date form completed:_______________________ Reviewed (please initial and date):_____________________

Reviewed (please initial and date):_____________________ Reviewed (please initial and date):_____________________

Reviewed (please initial and date):_____________________ Reviewed (please initial and date):_____________________

Reviewed (please initial and date):_____________________ Reviewed (please initial and date):_____________________