ST. BARNABAS SCHOOL

EMERGENCY MEDICAL AUTHORIZATION FORM 20____/20____

Purpose: To authorize emergency treatment for students who become ill or injured while under school authority, when parents or guardians cannot be reached. Please contact the school immediately if any information changes.

Family Name: _____ **Father's Name:** _____ **Mother's Name:**_____

Family Address: _____

City: _____**Zip Code:** _____ ****Email Address:** _____

*****REQUIRED*****

Please indicate Last name of child if different than parent _____

CHANGE IN MARITAL STATUS

☐ **No Change** ☐ **Divorced** ☐ **Separated** ☐ **Other**

Student Name_____Grade:_____ Room#_____ Student Name _____ Grade:_____ Room#_____

Student Name_____Grade:_____ Room#_____ Student Name _____ Grade:_____ Room#_____

Student Name_____Grade:_____ Room#_____ Student Name _____ Grade:_____ Room#_____

PLEASE CHECK BOX FOR CONTACT NUMBER TO BE USED FIRST IN AN EMERGENCY

Mother's Telephone	Father's Telephone
☐ (H) _____	☐ (H) _____
☐ (W) _____	☐ (W) _____
☐ (Cell) _____	☐ (Cell) _____

Custodial Parent: ☐ Both Parents ☐ Mother ☐ Father ☐ Joint ☐ Other: _____

In case of an emergency, illness, accident or early dismissal **AND THE PARENT CANNOT BE CONTACTED**, please contact and/or release my child to one of the following people:

Name	**Relationship to Child**	**Work/Home Phone Number**
_____	_____	_____
_____	_____	_____

PART I: TO GRANT CONSENT

I hereby grant consent for the following medical care providers and local hospital to be called:

Doctor/Phone: _____**Local Hospital/Emergency/Phone:** _____

Dentist/Phone: _____ **Medical Specialist/Phone:**_____

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 doctor 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 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:

_____

_____ _____

Date Signature of Parent / Guardian

DO NOT COMPLETE PART II IF YOU HAVE COMPLETED PART I

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 no action or to:

_____

_____ _____

Date Signature of Parent / Guardian

******NOTICE TO PARENTS** – The information on this form will be shared with your child's school bus driver. If for some reason you do not wish this information given, please notify the school in writing when this form is returned to school.