ST. ANTHONY OF PADUA SCHOOL
6800 State Road
Parma, Ohio 44134
440-845-3444

2018-2019 EMERGENCY MEDICAL AUTHORIZATION

(PLEASE PRINT WITH A BLACK INK PEN)

Student Name: _____ Date of Birth: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Grade: _____ Homeroom #: _____

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

Residential Parent or Guardian Information
Mother: _____ Cell #: _____ Daytime Phone: _____
Father: _____Cell #: _____ Daytime Phone: _____
Other Name: _____ Daytime Phone: _____

Name of Relative or Childcare Provider: _____ Relationship: _____
Address: _____City/State/Zip: _____ Cell #: _____

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT

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

Primary Physician: _____ Phone: ( )_____
Dentist: _____ Phone: ( )_____
Medical Specialist: _____ Phone: ( )_____
Local Hospital: _____ 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 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 surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history which a physician should be alerted:
Allergies: _____
Medications being taken: _____
Physical impairments: _____

Parent/Guardian Signature: _____ Date: _____
Address: _____ City/State/Zip: _____

(PLEASE REVIEW THE REVERSE SIDE OF THIS FORM FOR PART II: REFUSAL OF CONSENT)

PART II: REFUSAL OF CONSENT

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 school authorities to take the following action:

_____
_____
_____
_____
_____

Parent/Guardian Signature: _____ Date: _____
Address: _____ City/State/Zip: _____