ST. ALOYSIUS CATHOLIC CHURCH
150 S. ENTERPRISE STREET
BOWLING GREEN, OHIO 43402
419-352-4195

EMERGENCY MEDICAL AUTHORIZATION FORM
(Expires one year from date of signature)

Student Name _____

Address _____Zip _____

Telephone _____ email address _____

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

Residential Parent or Guardian:

Mother's Name _____ Daytime Phone _____

Father's Name _____ Daytime Phone _____

Other's Name _____ Daytime Phone _____

Name of Relative or Care Provider (other than parent):

_____Relationship _____

Address _____ Zip _____

Daytime Phone _____

Please note, to allow full participation in certain programs an Emergency Medical Authorization Form and a Program Participation Release of Liability Form for that specific activity must be completely filled out, including Part I or II on the reverse side of this form, prior to the event. Once the Emergency Medical Authorization Form is filled out completely the form is valid for one year from date of signature and will be kept on file by the Youth Coordinator at St. Aloysius Church. Each activity will have its own Program Participation Release of Liability Form. Any questions can be directed to the Youth Coordinator.

_____

(parent initials)

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 _____ 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 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.

Please identify any 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_____

_____Zip_____

PART ll: 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_____

_____Zip_____