EMERGENCY MEDICAL AUTHORIZATION

ONLY ONE FORM PER FAMILY IS NEEDED

Family Last Name_____ Phone #_____

Address_____

NAME OF EACH CHILD AND GRADE

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

PURPOSE

To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under the authority of St. Maximilian Kolbe Parish Religious Education Program, when parents or guardians cannot be reached.

In the event reasonable attempts to contact me at _____(phone #) or _____ (other family member) at _____(phone #) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____(preferred dentist), or in the event the designated preferred practioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to _____ (preferred hospital) or any hospital reasonable 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.

List any facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

_____

_____

_____

Date_____ Signature of Parent or Guardian_____

REFUSAL TO CONSENT

(Do not complete if you competed the top portion.)

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 authorities of St. Maximilian Kolbe Parish to take NO ACTION OR TO:_____

_____

Date:_____ Signature of Parent or Guardian:_____