ENROLLMENT

FORM – E703

Please complete a separate form for each student.

EMERGENCY MEDICAL AUTHORIZATION FORM
MARY, QUEEN OF HEAVEN SCHOOL

Student's Name: ______________________________ Grade: _____ Birth date: _________

Address: ____

City: __________________________ State: ______ Zip: _______ Phone: ___________

PURPOSE: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

MOTHER

Name: ________________________________ Employer: ____________________________

Address: ______________________________ Work Address: _________________________

City: __________ State: _____ Zip: ________ City: __________ State: ____ Zip: ________

Home Phone: ___________________________ Work Phone: ______________ Ext: ________

Pager Number: __________________________

Cellular Phone Number: ____________________

FATHER

Name: ________________________________ Employer: ____________________________

Address: ______________________________ Work Address: _________________________

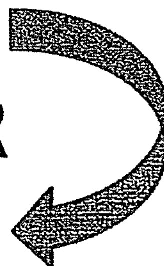
City: __________ State: _____ Zip: ________ City: __________ State: ____ Zip: ________

Home Phone: ___________________________ Work Phone: ______________ Ext: ________

Pager Number: __________________________

Cellular Phone Number: ____________________

OVER



PART I OR PART II MUST BE COMPLETED AND SIGNED

PART I – TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called in the event of an emergency:

Student's Doctor: ______________________________ Phone: ____________________

Dentist: ______________________________ Phone: ____________________

Local Hospital: ______________________________ ER Phone: ____________________

Insurance: ____

In the event of reasonable attempts to contact me have been unsuccessful. I hereby give my consent for 1) the administration of any treatment deemed necessary by the above-named practitioners, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist , and 2) the transfer of this 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.

Facts concerning this child's medical history (allergies, diseases, disorders, health conditions, medications being taken, physical impairments, etc.) to which a physician should be alerted:

Allergies: ____

Medications: ____

Diseases, health conditions, physical impairments: ______________________________

Other pertinent medical information regarding this child: ______________________________

____

Signature of Parent/Guardian: ______________________________ Date: ____________________

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 the following action: ____________

____

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Signature of Parent/Guardian: ______________________________ Date: ____________________