Cleveland Central Catholic High School

Emergency Medical Authorization Form (1/2017)

School Year 2017-2018

Purpose: To grant Cleveland Central Catholic authorization to contact emergency treatment for children who become ill or injured under school authority, when parents and guardians cannot be reached.

Student's Name: _____ Birth Date _____

Address: _____

City: _____ Zip Code: _____

Residential Parent or Guardian:

Mother's Name: _____ Phone (____) _____

Father's Name: _____ Phone (____) _____

Other: _____ Phone (____) _____

Name of Relative or Childcare Provider:

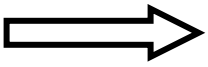
_____ Relationship: _____

Address:

_____ Daytime Phone (___) _____

City _____ Zip Code _____

Please complete either Parts I or II on the reverse side of this sheet.



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 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 opinion 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 physician should be alerted:

_____

_____

Date: _____ Signature of Parent/Guardian: _____

Address: _____

City: _____Zip: _____

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:

_____

_____

Date: _____ Signature of Parent/Guardian: _____

Address: _____

City: _____Zip: _____