EMERGENCY MEDICAL AUTHORIZATION

Holy Cross Catholic School

(ONE COPY PER STUDENT MUST BE FILED)

Student's Name ______________________________ **Summer Stem Day Camp June 1-5**

Student allergies ____

PART I OR II MUST BE COMPLETED

PART I TO GRANT CONSENT

In the event reasonable attempts to contact:

Mother's name ______________________________ Phone # ________________

Mother's employers name ______________________________ Phone # ________________

Father's name ______________________________ Phone # ________________

Father's employers name ______________________________ Phone # ________________

People to be contacted in the event of an emergency if the parent cannot be reached:

Name ________________________ Phone # ________________ relationship to child ________________

Name ________________________ Phone # ________________ relationship to child ________________

We have been unsuccessful; I hereby give consent for: (1) the administration of any treatment deemed necessary by:

______________________ ____________ or ________________________ ____________

(Preferred Physician) (Phone) (Preferred Dentist) (Phone)

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 ______________________________ ________________

(Preferred Hospital) (Phone)

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 the child's medical history including allergies, medications being taken and any physical impairments to which a physician should be alerted.

Signature: __________________________ __________________________ ____________

(Parent/Guardian) (Address) (Date)

PART II REFUSAL TO CONSENT

(Do not complete Part II if you completed Part I)

I do not give my consent for emergency medical treatment for my child in the event of illness or injury requiring emergency treatment. I wish the school authorities to take no action or to:

____

Signature:__________________________ __________________________ ____________

(Parent/Guardian) (Address) (Date)