EMERGENCY MEDICAL AUTHORIZATION

Student Name _____Home Room_____

Address_____Phone _____

Purpose: To enable parent(s)/guardian(s) to authorize the provision of emergency treatment for children who become ill or injured while under Columbus Preparatory Academy's authority, when parent(s)/guardian(s) cannot be reached.

Residential Parent(s)/ Guardian(s)

Mother's Name _____ Daytime Phone _____

Father's Name _____Daytime Phone _____

Other's Name _____ Daytime Phone _____

Name of Relative or Childcare Provider _____ Relationship _____

Address _____ Daytime Phone _____

PART I OR II MUST BE COMPLETED

PART I - TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ ER 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 doctor, or, in the event the designated 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 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: _____

_____

PART II - (DO NOT COMPLETE IF COMPLETED PART I) 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_____