ST. ROSE OF LIMA 2015-2016 Preschool Sunday School

Emergency Medical Authorization

FAMILY (Last Name) ______________________________ PHONE ______________________

ADDRESS ____

Child(ren)'s Name and Grade

1. ________________________________ 3. ________________________________

2. ________________________________ 4. ________________________________

Purpose

To enable parents/guardians to authorize the provision of emergency treatment for children who become ill/injured while under PREP authority, when parents/guardians can't be reached.

In the event reasonable attempts to contact me at ______________________________ (phone) or ____________________________________(other parent/guardian) are unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. (preferredphysician)________________________________Phone______________________ or Dr. (preferred dentist) ________________________________Phone __________________ , or in the event the designated preferred practitioner is not available, by another licensed physician/dentist; and (2) the transfer of the child to (preferred hospital) __________________ ____________________or any hospital reasonably accessible.

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This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Facts concerning the child(ren)'s medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted:

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Date: __________________ ____

Signature of Parent or Guardian

REFUSAL TO CONSENT *(DO NOT COMPLETE IF YOU COMPLETED 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 PREP authorities to take no action:

Date: __________________ ____

Signature of Parent or Guardian