# EMERGENCY MEDICAL AUTHORIZATION

***(please fill out one form for each student)***

## 2020-2021 SCHOOL YEAR

ST. MICHAEL CATHOLIC SCHOOL

Student Name _____ Grade _____ Homeroom _____

Address _____ City: _____ Zip _____

Home Phone _____ Mobile: _____

*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.* ***THREE (3) contacts MUST be listed.***

**Residential Parent or Guardian:**

Mother's First/Last Name _____ Day Phone _____ Mobile _____

Father's First/Last Name _____ Day Phone _____ Mobile _____

Other's First/Last Name _____ Day Phone _____ Mobile _____

Name of Relative or Childcare Provider _____ Relationship _____

Address _____ City: _____ Zip _____

Home Phone _____ Mobile: _____

**- PART 1 OR PART 2 MUST BE COMPLETED -**

### PART 1: 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 _____ Emergency Room Number _____

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 to 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 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 MEDICATIONS BEING TAKEN AND ANY PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED:**

_____

ALLERGIES: _____

Signature of Parent/Guardian _____ Date _____

Address _____ City: _____ Zip _____

### PART 2: REFUSAL TO CONSENT

**I do NOT give my consent** for emergency medical treatment of my child. In the event of illness or injury requirement emergency treatment, I wish the school authorities to take the following action:

_____

Signature of Parent/Guardian _____ Date _____

Address _____ City: _____ Zip _____

# PHYSICIAN & PARENT REQUEST FOR THE ADMINISTRATION OF MEDICATION BY SCHOOL PERSONNEL

***(please fill out one form for each student)***

## 2020-2021 SCHOOL YEAR

ST. MICHAEL CATHOLIC SCHOOL

Student Name _____ Grade _____ Date _____

Address _____

City _____ State _____ Zip _____

Name of Medication and dosage _____

Time(s) of day to be administered _____

Number of times/intervals medication is to be administered _____

Date to begin medication _____

Date to end medication _____

Adverse/severe reaction(s) that should be reported to Physician _____

Special instructions for administration of medication _____

This medication can be safely administered by non-medical personnel ☐ Yes ☐ No

It is impossible to arrange for this medication to be taken at home and, therefore, it must be administered during school hours ☐ Yes ☐ No

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This student is under my care. It is not possible to arrange for this medication to be taken at home under the supervision of a parent, and therefore it must be taken during school hours.

Physician Printed Name _____ Telephone # _____

Physician Signature _____ Date _____

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Please regard my signature below as my assurance that I release St. Michael School, St. Basil School, PSI, and any or all of the school and PSI's officers or employees from any liability or damages resulting from the consequences or adverse reactions of our child's taking, or failing to take, this medication at the times prescribed. I also agree to keep the school informed, in writing, of any revision in the physician's prescription. I have had the opportunity to ask questions. They have been fully answered to my satisfaction.

Parent Printed Name _____ Telephone # _____

Parent Signature _____ Date _____