ALL SAINTS CATHOLIC SCHOOL
EMERGENCY MEDICAL AND TRANSPORTATION AUTHORIZATION

Grade ________________ Student's Name____

Date of Birth_______________ Address____

Gender______________ Bus # ______________ Home Phone with area code(_____)____________________

Child lives with____Relationship____________________________

Mother's (Guardian) Name:____

Address:____

Phone:____Cell Phone:___________________________________

Employer's Name:____ Phone:_______________________

Address:____

Father's (Guardian) Name:____

Address:____

Phone:____Cell Phone:__________________________________

Employer's Name:____ Phone:____________________________

Address:____

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. In case of early dismissal for inclement weather or emergency situations, every attempt will be made to contact parent or emergency contact. If this is not possible, I request that you
_________________send my child(ren) home on the bus _________________hold my child(ren) at school

People **other than parents/guardians** to be contacted in the event of an emergency if the parent cannot be reached:

Name:____

Address:____

Relationship to o child:_______________________________________Phone:_________________________________

Name:____

Address:____

Relationship to child:____Phone:__________________________________

PART I OR II MUST BE COMPLETED ON THE REVERSE SIDE.

****ALONG WITH FACTS CONCERNING CHILD'S MEDICAL HISTORY – BOTTOM OF REVERSE SIDE****

COMPLETE EITHER PART I OR II BELOW. DO NOT COMPLETE BOTH.

Part 1 Permission to treat/transport child: In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by doctor named or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and the transfer of the child to any hospital reasonably accessible. Include all phone numbers.
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.

I give ____ permission to treat or
Name of school

transport my child ____to:
Name of Child

Doctor_____________________________________Phone___________________________________

Address____

Dentist_____________________________________Phone___________________________________

Address____

Medical Specialist_____________________________Phone___________________________________

Address____

Local Hospital Emergency Room____

Address_____________________________________Phone___________________________________

Parent's Signature:____Date:___________

Part 2 Refusal to grant permission:

I do not give permission to ____
Name of school

For emergency medical treatment of my child ____
Name of Child

**In the event of an illness or injury which requires emergency medical or dental treatment, I wish the following actions to be taken:

Parent's Signature:____Date:___________

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

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