

St. Thomas Aquinas High School
2121 Reno Drive NE
Louisville, Ohio 44641
(330) 875-1631
Diocese of Youngstown

**EMERGENCY MEDICAL AUTHORIZATION FORM
(Summer Gym)
2010**

Student Name _____ Grade _____
Address _____ Zip _____
Student lives with _____

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.

First **Parent** Contact: _____ Daytime phone _____
Second **Parent** Contact: _____ Daytime phone _____
Third Contact _____ Daytime phone _____
 ↳ Relationship _____
Fourth Contact _____ Daytime phone _____
 ↳ Relationship _____

TO GRANT CONSENT

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

Physician: _____ Phone _____
Dentist: _____ Phone _____
Medical specialist _____ Phone _____
Local Hospital _____ 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 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 each surgery, are obtained prior to the performance of such surgery.

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

Signature _____ Date _____

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 to take the following action: _____.

Signature: _____ Date _____