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

EMERGENCY MEDICAL AUTHORIZATION FORM
2018 - 2019

Student Name _____Grade _____ Cell #_____
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 # _____Cell_____
Second **Parent** Contact: _____Daytime # _____Cell_____
Third Contact _____ Daytime # _____Cell_____
└ Relationship_____
Fourth Contact _____Daytime phone _____Cell_____
└Relationship_____

Parent Email address_____

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_____