Chaminade-Madonna College Preparatory

500 Chaminade Drive • Hollywood, FL 33021 • (954) 989-5150

EMERGENCY MEDICAL AUTHORIZATION

Student Name:_____ School:_____

Address:_____ School Year:_____

Telephone:_____ School Attended:_____

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Part I or Part II must be completed.

PART I (To Grant Request)

In the event reasonable attempts to contact me at _____(phone) or to contact other parent, _____(name) at _____(phone), have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred dentist), or Dr. _____(preferred physician), 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 _____ (preferred hospital) or 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 before surgery is performed.

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

_____

_____ _____

Parent Signature Date

_____

Address

PART II (Refusal to Consent)

Do not complete PART II if you completed PART I.

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 authorities to take no action or to:

_____

_____ _____

Parent Signature Date

_____

Address