Our Lady of the Lake School

Pre-Kindergarten Emergency Medical Authorization

Child's Name: ______________________________ Date: ____________
Address: ______________________ Zip: ________ Phone: ____________
Father's Place of Business: ______________________ Phone: ____________
Mother's Place of Business: ______________________ Phone: ____________

If your child becomes ill and both parents work, which parent should be called first? ____________

Persons To Be Notified If Parents Cannot Be Reached

1. Name: ______________________________ Phone: ____________
2. Name: ______________________________ Phone: ____________

Purpose: Persons given permission to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

Person(s) given permission to provide emergency transportation. ____________________

Part 1 (To Grant Consent)

In the event reasonable attempts to contact me at (___)__________, or other parent at (___)________ have been unsuccessful, I hereby give my consent for [1.] the administration of any treatment deemed necessary by Dr. __________ (preferred doctor) or Dr. ______________ (preferred dentist) or in the event the designated prefered 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 the surgery is performed.

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

____

______________________ ______________________ __________

Father's Signature Mother's Signature Date

Do Not Complete Part 2 If You Completed Part I

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 requiring emergency medical treatment, I wish the school authorities to take no action or to: ______________________

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____

____

______________________ ______________________ __________

Father's Signature Mother's Signature Date

STUDENT NAME ______________________

Preschool Emergency Medical Authorization (Additional Contact Information)

Preferred Physician: ______________________

Address: ______________________ Phone: ______________________

Preferred Dentist: ______________________

Address: ______________________ Phone: ______________________

Local Preferred Hospital: ______________________

Location: ______________________

Emergency Room Phone: ______________________

Preschool Emergency Medical Authorization (Additional Contact Information)

Preferred Physician: ______________________

Address: ______________________ Phone: ______________________

Preferred Dentist: ______________________

Address: ______________________ Phone: ______________________

Local Preferred Hospital: ______________________

Location: ______________________

Emergency Room Phone: ______________________