EMERGENCY MEDICAL AUTHORIZATION FORM
William V. Fisher Catholic High School

Student Name: _____ Birth Date: _____ Grade: _____

Address: _____ City/Zip Code: _____

Home Phone #: _____Mom's Cell # _____ Dad's Cell #_____

Student lives with: ___Both Parents ___Mother ___Father ___Guardian ___Step-Parent
Parents are: ____Married ___Divorced ___Separated ___Widowed

Is there a court custody order pertaining to this child? _____ Who has custody? _____
A copy of custody papers is REQUIRED to be on file

PARENT/GUARDIAN(S) AND EMERGENCY CONTACTS

Call Order:	Name:	Relationship:	Day Phone:	Cell Phone:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Please indicate if your child has any of the following:

1) Allergies (please list):_____
_____

2) Medications* (please list**):**_____
_____

3) Inhalers* (please list): _____

4) Other medical concerns orconditions to which medicalpersonnel should be alerted?
_____
_____
_____

*** Use and/or possession of any medications, whether prescribed or not, requires the appropriate documentation to be completed and on file with the school.**

PART I *OR* PART II *MUST BE COMPLETED*

PART I: TO GRANT CONSENT

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

Physician: _____ Phone _____
Dentist: _____ Phone _____
Medical Specialist: _____Phone _____

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemednecessary by the appropriate medical professional; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does notcover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, areobtained prior to the performance of such surgery.

_____ _____
Signature of Parent/Guardian for Grant to Consent **Date**

PART II: REFUSAL TO CONSENT

I do NOT give consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wishthe school authorities to take the following action:

_____
_____
_____

_____**Signature of Parent/Guardian for Refusal to Consent** **Date**