6/19/2018

EMERGENCY MEDICAL AUTHORIZATION
2018-2019

Christ Our Savior Lutheran High School
810 Soldiers Way
Evansville, IL 62242
School telephone
618/853-7300

____
Student's Name

____
Address City

____
Telephone Place of Birth Date of Birth

Purpose – to enable parents and guardians to authorize the provision of emergency care for children who become ill while under school authority, when parents or guardians cannot be reached.

Part I OR Part II Must Be Complete
Part I to Grant Consent

In the event that reasonable attempts to contact me at____________________________________ (Phone Number) or ____ (Other parent or guardian and phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _________________________ (Preferred Physician) or by Dr.________________________________(Preferred dentist) 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 dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery. Facts concerning the child's medical history including allergies, medications taken, and any physical impairment to which a physician should be alerted:____
____
____

Additional phone numbers ____________________________ __________________________

_______________________________ ____
Date Signature of Parent or Guardian

____
Address

Do Not Complete Part II if You Completed Part I
Part II 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 authorities to take no action or to:

____
____

_______________________________ ____
Date Signature of Parent or Guardian