

IMMACULATE HEART of MARY AFTER-SCHOOL CARE MEDICAL FORM

STUDENT'S NAME: _____

EMERGENCY NAMES AND NUMBERS WHERE YOU OR PERSON YOU DESIGNATE MAY BE REACHED DURING AFTER-SCHOOL CARE HOURS:

- | | |
|----------|----------|
| NAME: | NUMBERS: |
| 1. _____ | _____ |
| 2. _____ | _____ |

PART I OR II MUST BE COMPLETED:

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact me at _____ (phone) or _____ (other parent or guardian) at _____ (phone) have been unsuccessful, I hereby give consent for:

- 1.) The administration of any treatment deemed necessary by Dr. _____ (preferred physician) at _____ (phone) or, Dr. _____ (preferred dentist) at _____ (phone) 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.

FACT'S CONCERNING THE CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES, MEDICATIONS AND ANY PHYSICAL CONDITIONS WHICH THE PHYSICIAN AND SCHOOL SHOULD BE INFORMED OF: _____

Signature of Parent or Guardian

Date

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 any illness or injury requiring treatment, I wish the school authorities to take no action or to: _____

Signature of Parent or Guardian

Date