SCHOOL CLINIC

ST. VINCENT-ST. MARY HIGH SCHOOL

15 North Maple Street • Akron, Ohio 44303 • (330) 253-9113 • fax (330) 996-0000

EMERGENCY MEDICAL FORM

Purpose: To enable parents to authorize or otherwise direct emergency treatment for children who become ill or injured while under school authority when parents cannot be reached.
Please print clearly, using no abbreviations or nicknames. Thank you.

COMPLETED FORM MUST BE ON FILE PRIOR TO THE FIRST DAY OF SCHOOL.

Student Name _____ Year of Graduation _____

Address _____

City/State _____ Zip _____ Phone _____

Last School Attended _____

Residential Parent or Guardian:

Mother _____ Daytime Phone _____

Father _____ Daytime Phone _____

Other _____ Daytime Phone _____

Relative or caregiver authorized to be called if parent/guardian cannot be reached:

Name _____ Relationship _____

Daytime Phone _____

Address _____ City/State/Zip _____

Part I or Part II below must be completed.

Part I. TO GRANT CONSENT

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

Physician: _____ Phone: _____

Dentist: _____ Phone: _____

Specialist: _____ Phone: _____

Local Hospital _____ Emergency Room Phone: _____

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for 1) the administration of any treatment deemed necessary by above-named doctors, or in the event the designated preferred practitioner is not available, by another licensed professional, and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not grant consent for major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

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

_____

Signature of Parent/Guardian _____ Date _____

Address _____ City/State/Zip _____

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 medical treatment, I wish the school authorities to take the following action: _____

_____

_____

Signature of Parent/Guardian _____ Date _____

Address _____ City/State/Zip _____

revised 1/30/17