

GESU CATHOLIC SCHOOL
AUTHORIZATION

2020-2021 SCHOOL YEAR

EMERGENCY MEDICAL

PLEASE FILL OUT ONE FORM FOR EACH CHILD.

NAME: _____ D.O.B. _____ GRADE: _____
ADDRESS: _____ CITY/STATE/ZIP: _____ PHONE: _____
MOTHER'S FULL NAME _____ WORK #: _____ FATHER: NAME _____ WORK #: _____
CELL PHONE NUMBERS: MOM: _____ DAD: _____

WHICH PARENT SHOULD WE CONTACT FIRST _____

EMERGENCY TELEPHONE NUMBERS WHEN PARENTS ARE NOT AVAILABLE:

NAME: _____ RELATIONSHIP: _____ PHONE: _____
NAME: _____ RELATIONSHIP: _____ PHONE: _____
NAME: _____ RELATIONSHIP: _____ PHONE: _____

FACTS CONCERNING YOUR CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES, MEDICINES BEING TAKEN, OR PHYSICAL LIMITATIONS
THAT THE SCHOOL NURSE SHOULD BE AWARE OF:

TO GRANT CONSENT

I HEREBY GIVE CONSENT FOR THE FOLLOWING MEDICAL CARE PROVIDERS AND LOCAL HOSPITALS TO BE CALLED:

PHYSICIAN: _____ PHONE: _____
DENTIST: _____ PHONE: _____
MEDICAL SPECIALIST (IF APPLICABLE): _____ PHONE: _____
HOSPITAL: _____ PHONE: _____

IN THE EVENT 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 PHYSICIAN OR DENTIST; AND (2) THE TRANSFER OF THE CHILD TO 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 PRIOR TO THE PERFORMANCE OF SUCH SURGERY.

DATE: _____ SIGNATURE OF PARENT OR GUARDIAN: _____ PHONE: _____

IF YOU DO NOT WISH EMERGENCY TREATMENT OF ANY KIND FOR YOUR CHILD, PLEASE STATE IN WRITING WHAT YOU WANT US TO DO.