

St. Barnabas  
Parish School of Religion  
Emergency Medical Authorization Form

**Purpose:**

To enable parents/guardians to authorize emergency treatment for children who become ill or injured while attending P.S.R., when parents/guardians cannot be reached.

**Either PART I OR PART II must be completed (Do not complete both parts). PLEASE PRINT**

**PART I (To Grant Consent)**

Children's Names \_\_\_\_\_

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

- (1) the administration of any treatment deemed necessary by Dr. \_\_\_\_\_ (preferred doctor) or 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 reasonably accessible hospital.

This authorization does not cover any major surgery unless the medical opinions of two (2) other licensed physicians or dentists concur in the necessity for such surgery and concurrence is obtained before the surgery is performed.

Facts concerning the child's medical history including allergies, *medications and reason being taken*, and any physical impairment to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date      Parent or Legal Guardian Signature      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 emergency treatment being required, I wish the school authorities to take no action or to:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Date      Parent or Legal Guardian Signature      Address**