The Welsh Academy

AT SAINT IGNATIUS

In Honor of Rev. Robert J. Welsh, S.J. '54

Emergency Medical Authorization Form

Student's Name: _____ Grade_____

Street Address: _____

City: _____ Zip Code: _____ Telephone Number: _____

Purpose: To enable Parents and Guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when Parents or Guardians cannot be reached.

Residential Parent or Guardian:

Mother's Name: _____ Phone: (_____) _____

Father's Name: _____ Phone: (_____) _____

Other's Name: _____ Phone: (_____) _____

Name of Primary Relative or Childcare Provider: This is the person you would like us to contact in case we are not able to contact you in case of an emergency.

Name: _____ Relationship:_____

Address: _____ Daytime Phone:_____

City:_____ Evening Phone: _____

Zip Code: _____ Cell Phone:_____

Name of Secondary Relative or Childcare Provider: This is the person you would like us to contact in case we are not able to contact you in case of an emergency.

Name: _____ Relationship:_____

Address: _____ Daytime Phone:_____

City:_____ Evening Phone: _____

Zip Code: _____ Cell Phone:_____

Student Medical Background:

It is very important to complete the medical concerns section so that the school is aware of any potential emergency challenges. Medical concerns will be shared with your son's teachers and staff only on a need to know basis. If you have any additional concerns, please contact the school nurse directly at 216-634-8818.

Does your son have any medical concerns: Yes _____ No _____

Check any that apply:

_____ Asthma _____ Diabetes _____ Seizure Disorder

The Welsh Academy

AT SAINT IGNATIUS

In Honor of Rev. Robert J. Welsh, S.J. '54

Please list if there are other medical concerns to which the school should be alerted:

_____

Does your son have a severe allergy to:

_____Food _____Stinging Insects _____ Other

Please list if there are other allergies:_____

List any other medications and any physical impairment to which a physician should be alerted:

_____

_____

Part I: APPROVAL to Grant Consent

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

Physician: _____Phone: (_____)_____
Dentist: _____Phone: (_____)_____
Medical Specialist: _____Phone: (_____)_____
Local Hospital: _____ ER 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 practitioner is not available, by another licensed physician or dentist; and **2)** the transfer of the child to any hospital reasonably accessible.

The authorization does not cover major surgery unless the medical opinions of two (2) other licensed physicians or dentists, 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 being taken, and any physical impairments to which a physician should be alerted:

Parent/Guardian Signature:_____ Date:_____

Part II: REFUSAL to Grant 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 the following action:

Parent/Guardian Signature:_____ Date:_____

Office Use Only: Date Received:_____