St. Christopher Parish PSR Emergency Medical Authorization 2020-2021

Purpose: To enable parents/guardians to authorize emergency treatment for children who become ill or injured while under the authority of the St. Christopher Parish PSR program when parents/guardians cannot be reached.

**Part I OR Part II MUST be completed and returned to the Religious Education Office with Registration. ONE PER CHILD**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_

## Part I: TO GRANT CONSENT

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/phone) or Dr.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (preferred dentist/phone) or in the event the designated preferred physician 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 being taken, and any physical impairments to which a physician should be alerted. **If none, please write, “none known at this time.**”

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Please include any educational needs that we need to be made aware of – i.e: ADHD, Autism, behavioral issues, etc.

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Date Parent/Guardian Signature Address

Please list the name(s), the relationship and phone number(s) of person(s) we might call in case of an emergency or sickness and you are not home.

Name Relationship Phone Number

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# **DO NOT complete this part 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 required, I wish the church authorities to take no action or to:**

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#### Date Parent/Guardian Signature Address