ATHLETICS
ST. VINCENT-ST. MARY HIGH SCHOOL
15 NORTH MAPLE STREET · AKRON, OH · 44303 (330) 253-9113

2010-2011 EMERGENCY MEDICAL AUTHORIZATION

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 Code:____________________

Home Phone: ______________________________

Residential Parent or Guardian:

Mother: ______________________________ Cell Phone:____________________

Father: ______________________________ Cell Phone:____________________

Other: ______________________________ Cell Phone:____________________

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

Name: ______________________________ Relationship:____________________

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:______________________________ Phone #:______________________________

Insurance Provider:______________________________ Insurance #:______________________________

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 practioner 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 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:______________________________

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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:______________________________

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Signature of parent/guardian: ______________________________ Date:____________________