

ST. GABRIEL CONSOLIDATED SCHOOL

Emergency Card

Student Name _____ Grade _____

Address _____

City _____ Zip Code _____

Telephone Number _____ Birthdate _____

Father/Guardian's Name _____

Address (if different from above) _____

Home Telephone Number _____ Work Telephone Number _____

Cellular Number _____ Pager Number _____

Place of Employment _____

Mother/Guardian's Name _____

Address (if different from above) _____

Home Telephone Number _____ Work Telephone Number _____

Cellular Number _____ Pager Number _____

Place of Employment _____

In the event this student becomes ill at school but does not need medical attention,
Name two people to be contacted if you cannot be reached:

Name _____ Telephone _____

Is this person a neighbor or a relative _____

Name _____ Telephone _____

Is this person a neighbor or a relative _____

PLEASE COMPLETE BOTH PAGES

EMERGENCY MEDICAL AUTHORIZATION

(State of Ohio Revised Code Section 3313.712)

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.

PART I OR PART II MUST BE COMPLETED

PART I To Grant Request

In the event reasonable attempts to contact me or (other parent's name) _____ have been unsuccessful (see other page for phone numbers where I/we can be reached), I hereby give my consent for: (1) the administration of any treatment deemed necessary by (preferred physician) Dr. _____ or (preferred dentist) Dr. _____, 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 hospital reasonable accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessary for such surgery, are obtained before surgery is performed.

Physician's Phone Number _____ Dentist's Phone Number _____

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

Date _____ Signature of parent/guardian _____

(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 injury requiring medical treatment, I wish the school authorities to take no action or to: _____

Date _____ Signature of parent/guardian _____

PLEASE COMPLETE BOTH PAGES