

ST. GABRIEL CONSOLIDATED SCHOOL

Emergency Form

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 _____

Place of Employment _____

Mother/Guardian's Name _____

Address (if different from above) _____

Home Telephone Number _____ Work Telephone Number _____

Cellular 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 _____

EMERGENCY MEDICAL AUTHORIZATION

St. Gabriel Consolidated School

Student Name _____

Date of Birth _____

Grade _____

Teacher _____

Address _____ City _____ State _____ Zip _____ Telephone _____

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

A. Residential Parent/Guardian

Mother's Name _____ Daytime Phone Number _____ Cell _____

Father's Name _____ Daytime Phone Number _____ Cell _____

Other Name/Relationship _____ Daytime Phone Number _____

B. Name of Relative or Childcare Provider

Name _____ Relationship _____

Address _____ Phone Number _____

***** **PART I OR PART II MUST BE COMPLETED AND SIGNED** *****

PART I MUST BE COMPLETED TO GRANT CONSENT: I HEREBY GIVE CONSENT FOR THE FOLLOWING MEDICAL CARE PROVIDERS/LOCAL HOSPITAL TO BE CALLED/TO BE TRANSPORTED TO HOSPITAL

Doctor's Name	Phone Number
Dentist's Name	Phone Number
Medical Specialist (if applicable)	Phone Number
Preferred Hospital	

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) emergency transportation for my child in the event of illness or injury which requires emergency treatment (2) the administration of any treatment deemed necessary by above-named doctor, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist, and (3) the transfer of the child to 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 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:

Date _____ Signature of Parent/Guardian _____
Address _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

PART II- REFUSAL TO CONSENT

I **DO NOT** give my consent for emergency transportation of and/or 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.

Date _____ Signature of Parent/Guardian _____
Address _____