EMERGENCY MEDICAL AUTHORIZATION

Student: _____ Grade_____ Home Phone: _____

Address_____ Email:_____

Mothers' Name: _____ Work Phone: _____ Cell Phone: _____

Fathers' Name: _____ Work Phone: _____ Cell Phone: _____

Alternate Persons to Contact: (People to contact if your child is ill and neither parent can be reached.)

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments or medical condition which the school or an emergency physician should know.

_____

_____

Public School District of Residence_____ Public School would Attend_____

Purpose: To enable parents or 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.
I hereby give consent for the following medical care providers and local hospital to be called:

Doctor_____ Phone_____

Dentist_____ Phone_____

Medical Specialist_____ Phone_____

Hospital_____
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 doctor, 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 any hospital reasonably 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:

Signature_____ Date_____

Refusal to 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:

_____

_____

Signature_____ Date_____

Regina Coeli Catholic School

REGINA COELI
CATHOLIC SCHOOL

Pick Up List 2022-23 Grades K-5

Child's Name:_____

Please list the names of the people other than the parents that may be picking up your child from school.

1._____ **Phone**_____

Relationship to child_____

2._____ **Phone**_____

Relationship to child_____

3._____ **Phone**_____

Relationship to child_____

4._____ **Phone**_____

Relationship to child_____

5. _____**Phone**_____

Relationship to child _____

Revised 2/22