

**Holy Angels Parish**  
**PARISH SCHOOL OF RELIGION**  
**EMERGENCY MEDICAL AUTHORIZATION**

**Date:** \_\_\_\_\_

Student Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**Purpose** – to enable parents and guardians to authorize the provision of emergency treatment for children whom become ill or injured while under PSR authority, when parents or guardians cannot be reached.

**Residential Parent or Guardian:**

Mother's Name \_\_\_\_\_ Phone \_\_\_\_\_  
(First) (Last)

Father's Name \_\_\_\_\_ Phone \_\_\_\_\_  
(First) (Last)

Name of Relative or Childcare Provider FOR EMERGENCY CONTACT:  
\_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_

**TO GRANT CONSENT**

I hereby give consent for the following medical care providers and local hospital to be called:

Physician \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_

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 doctors, 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 impairment to which a physician should be alerted:

\_\_\_\_\_  
\_\_\_\_\_

Date \_\_\_\_\_ Signature of Parent/Guardian \_\_\_\_\_

**PLEASE FILL OUT AND RETURN WITH REGISTRATION FORM**

