EMERGENCY MEDICAL AUTHORIZATION
ST. AUGUSTINE SCHOOL / 2025-2026

Student Full Name _____ Date of Birth _____ Grade _____

Address _____ City _____ State _____ Zip _____

Home telephone _____ Family Email Address: _____

PURPOSE: To enable parents and 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.

•Parent/Responsible Adult #1: Mother ☐ Father ☐ Guardian ☐ Other ☐

First Name _____ Last Name _____

Address (if different from student) _____

Primary Phone No. _____ Type: Home ☐ Cell ☐ Work ☐

Secondary Phone No. _____ Type: Home ☐ Cell ☐ Work ☐

Email _____

•Parent/Responsible Adult #2: Mother ☐ Father ☐ Guardian ☐ Other ☐

First Name _____ Last Name _____

Address (if different from student) _____

Primary Phone No. _____ Type: Home ☐ Cell ☐ Work ☐

Secondary Phone No. _____ Type: Home ☐ Cell ☐ Work ☐

Email _____ Permission to contact: Yes ☐ No ☐

Parents' status (circle one): Married / Divorced / Separated / Deceased /Single / Remarried

Are there any court documents pertaining to custody?: Yes ☐ No ☐

List 3 relatives/neighbors/friends that are authorized to pick your child up with your consent and/or assume temporary care if you cannot be reached:

1. Name _____ Phone: _____

   Address _____ Relationship: _____

2. Name _____ Phone: _____

   Address _____ Relationship: _____

3. Name _____ Phone: _____

   Address _____ Relationship: _____

Facts concerning your child's medical history, including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

Allergies: Other Conditions:

Remarks:

PART 1- TO GRANT CONSENT: **I HEREBY GIVE CONSENT for the following medical care providers/hospital to be called:**

Physician _____ Medical Specialist _____ Dentist _____

Phone _____ Phone _____ Phone _____

Preferred Local Hospital _____ ***** Permission to transport via Private Ambulance: (Please circle Yes or No)**

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.

Signature of Parent/Guardian _____ Date _____

Address _____ City _____ State ____ Zip _____ Telephone _____

PART 2- 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 of Parent/Guardian _____ Date _____

Address _____ City _____ State ____ Zip _____ Telephone _____