

**BISHOP LEIBOLD SCHOOL**  
**EMERGENCY MEDICAL AUTHORIZATION FORM**

STUDENT NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

\*ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ ZIP \_\_\_\_\_

\*TELEPHONE \_\_ (\_\_\_\_) \_\_\_\_\_ GRADE \_\_\_\_\_

\* \_\_\_\_\_ \* PLEASE CHECK IF THE ABOVE DATA IS NEW SINCE REGISTRATION

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.

Residential Parent or Guardian (\*\*Please indicate whom we should try to reach first\*\*)

Mother's Name \_\_\_\_\_ Daytime Phone \_ (\_\_\_\_) \_\_\_\_\_  
(First) (Last) Pager or cell phone \_ (\_\_\_\_) \_\_\_\_\_

Father's Name \_\_\_\_\_ Daytime Phone \_ (\_\_\_\_) \_\_\_\_\_  
(First) (Last) Pager or cell phone \_ (\_\_\_\_) \_\_\_\_\_

Other's Name \_\_\_\_\_ Daytime Phone \_ (\_\_\_\_) \_\_\_\_\_  
(First) (Last)

Name of Relative or Childcare Provider

\_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Daytime Phone \_ (\_\_\_\_) \_\_\_\_\_

\_\_\_\_\_ Zip \_\_\_\_\_

**PART I OR II MUST BE COMPLETED**  
(See Reverse Side)

**PART 1: 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 \_(\_\_\_\_)\_\_\_\_\_

Local Hospital \_\_\_\_\_ 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 dentist, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

**\*\*Medical Health Information:** Facts concerning the child’s medical history to which a physician should be alerted:

**allergies:** \_\_\_\_\_

**recommended treatment:** \_\_\_\_\_

**medications being taken:** \_\_\_\_\_

**health conditions:** \_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_ Signature of Mother/Guardian \_\_\_\_\_

Date \_\_\_\_\_ Signature of Father/Guardian \_\_\_\_\_

**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 emergency treatment, I wish the school authorities to take the following action:

\_\_\_\_\_

\_\_\_\_\_

Date \_\_\_\_\_ Signature of Mother/Guardian \_\_\_\_\_

Date \_\_\_\_\_ Signature of Father/Guardian \_\_\_\_\_