



Holy Cross Catholic School
Emergency Medical Authorization
(2024-2025)

Student Name: _____ Grade _____

PART I OR II MUST BE COMPLETED

PART I: TO GRANT CONSENT

In the event reasonable attempts to contact:

Mother's name _____ Phone # _____

Mother's employers name _____ Phone # _____

Father's name _____ Phone # _____

Father's employers name _____ Phone # _____

People to be contacted in the event of an emergency if the parent cannot be reached:

Name _____ Phone # _____ relationship to child _____

Name _____ Phone # _____ relationship to child _____

We have been unsuccessful; I hereby give consent for:

(1) the administration of any treatment deemed necessary by:

_____ or _____
(Preferred Physician) (Phone) (Preferred Dentist) (Phone)

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 _____
(Preferred Hospital) (Phone)

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: _____
(Parent/Guardian) (Address) (Date)



PART II REFUSAL TO CONSENT

(Do not complete Part II if you completed Part I)

I do not give my consent for emergency medical treatment for my child in the event of illness or injury requiring emergency treatment. I wish the school authorities to take no action or to:

Signature: _____ (Date)

(Parent/Guardian)