



Holy Cross Catholic School  
Emergency Medical Authorization  
(2025-2026)

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)



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**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:

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Signature: \_\_\_\_\_ (Date)

(Parent/Guardian)