EMERGENCY MEDICAL AUTHORIZATION 2018-2019
FOR YOUR CHILD'S SAFETY PLEASE RETURN THIS TO SCHOOL

Teacher ______________________________

Grade ____________ HR _________

Name ____ Sex _____ Race _________
First Middle Last

Address __________________________________ Apt. No._____ Zip __________ Phone ____________

Date of Birth _____________ ____ Birth Place ______________________________ Religion: ____________________
City, State

Mother's email ______________________________ Father's email ______________________________

Mother's Name ____ Circle one: Living Deceased
(Last) (First)

Mother's Place of Employment ________________________ Work Phone _________ Cell Phone __________

Father's Name ____ Circle one: Living Deceased
(Last) (First)

Father's Place of Employment ________________________ Work Phone _________ Cell Phone __________

Legal Guardian/Other Adult ____ Relationship __________

Guardian's Place of Employment ________________________ Work Phone _________ Cell Phone __________

Family Status of Parents: Circle One: Married Single Divorced Separated Remarried

Student is living with ____

Emergency person to be called in event parent cannot be reached.

1. Name ________________________________ Phone ________________________________

Relationship ________________________ Alt. Phone No. ____________________________

2. Name ________________________________ Phone ________________________________

Relationship ________________________ Alt. Phone No. ____________________________

Medical Information

Child's Social Security # * ____________________ Religion: ____________________________

Allergies ____

Medications ____

Chronic Conditions (e.g. ADHD, Asthma) ____

Medical Insurance Co. __________________________________ Policy No. ___________________

Member's Name ________________________________

Member's Birth date ___/___/_____ Member's Soc. Sec.# * __________________________

*Social Security number is optional. Please note that some hospitals **WILL NOT** treat without it.

** PLEASE COMPLETE & SIGN BACK OF FORM **

Please list other family members attending St. Martin School.

Student Name	**Grade/Room No.**	**Relationship**
1.		
2.		
3.		
4.		

TRANSPORTATION INFORMATION: ____ My child has my permission to walk home. Alone? ___ YES ____ NO
Only with ____________________________ My child will be picked up by car by ______________________
Is there anyone NOT permitted to pick up your child? _______ YES ________ NO
Name of the person NOT permitted to pick up above listed student: ___________________________
Relationship to child: __________________
If someone other than the above listed individuals will be picking your child up, or transportation arrangements will be different please contact the school via phone (513) 661-7609 to inform us of the change.

TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospitals 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 reasonable accessible.

The 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.

Date ________________

Signature of Parent/Guardian ____

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 the Parent/Guardian ____

PLEASE ONLY SIGN TO GRANT CONSENT OR REFUSAL TO CONSENT