ELYRIA CATHOLIC HIGH SCHOOL
Emergency Medical Authorization

_____ _____
Student's Name Phone

_____ _____
Address City

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached.
PART I or II MUST BE COMPLETED

PART I - GRANTING CONSENT

In the event reasonable attempts to contact me at _____(phone number) or _____ other parent or guardian name) at _____(phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____ (preferred physician) or Dr. _____ (preferred dentist) or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; (2) the transfer of the child to _____ (preferred hospital) or 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 before the surgery is performed.

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

_____

_____

We consent to the participation of the above-named student in the interscholastic program including practice sessions and travel to and from athletic contests and practices. We have read and understand the O.H.S.A.A. athletic eligibility information contained in the Student Handbook.

_____ _____ _____
Date Signature of Parent/Guardian Address

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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PART II - REFUSAL TO GRANT 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 **NO ACTION** or to: ***(Please specify details as to reason)***

_____

_____ _____ _____
Date Signature of Parent/Guardian Address