Greek Language School
Annunciation Cathedral
Columbus, Ohio

Emergency Medical Authorization

Student Name_____

Home Address _____
Zip Code

Parent/Guardian _____

Home Telephone ( ) _____Cell ( )_____

Email address*_____@_____

***Purpose: to enable parents, when they cannot be reached, to authorize emergency treatment for children who become ill under school authority.**

Parts 1 or 2 <u>MUST</u> be completed

Part 1 (TO GRANT REQUEST)

In the event reasonable attempts to contact me _____
Name and phone number

_____(other parent)_____
Name and phone number

are unsuccessful, I hereby grant my consent (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 and (2) the

transfer of the child to _____or any hospital reasonably accessible.
Preferred hospital

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 surgery is performed.

Facts concerning the child's medical history concerning ALLERGIES, MEDICATIONS BEING TAKEN, and PHYSICAL IMPAIRMENTS TO WHICH THE PHYSICIAN SHOULD BE ALERTED

_____

_____

Signature of Parent/Guardian **Date** **Address**

<u>DO NOT COMPLETE PART 2 IF YOU HAVE COMPLETED PART 1</u>

Part 2 (REFUSAL TO CONSENT)

I <u>DO NOT</u> give my consent for emergency treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities take no action or to

_____

_____

_____

Signature of Parent/Guardian **Date** **Address**