

**DO NOT FOLD - EMERGENCY MEDICAL AUTHORIZATION**  
**Newark Catholic High School**

STUDENT \_\_\_\_\_ DOB \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_  
TELEPHONE (res) (\_\_\_\_\_) \_\_\_\_\_ (work) (\_\_\_\_\_) \_\_\_\_\_  
HEALTH INSURANCE \_\_\_\_\_ CODE (if needed) \_\_\_\_\_

**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 Part II MUST be completed**

**PART I (to grant consent)**

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

\_\_\_\_\_  
In the event reasonable attempts to contact me at:  
(phone) \_\_\_\_\_ or (phone) \_\_\_\_\_  
have been unsuccessful, I hereby give my consent for:

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

**(Physician)** Dr. \_\_\_\_\_

Address \_\_\_\_\_

Telephone\_(\_\_\_\_\_) \_\_\_\_\_

**(Dentist)** Dr. \_\_\_\_\_

Address \_\_\_\_\_

Telephone\_(\_\_\_\_\_) \_\_\_\_\_

If the designated preferred practitioner is not available, another licensed physician or dentist has my permission to give treatment.

**(2)** and 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.

Signature of Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_  
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**PART II (refusal to consent)**

**I DO NOT GIVE 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:

\_\_\_\_\_  
\_\_\_\_\_

Signature of Parent \_\_\_\_\_ Date: \_\_\_\_\_