St. Brendan School
4242 Brendan Lane
North Olmsted, Oh 44070
Phone: 440.777.8433 / Facsimile: 440.779.7997

MEDICAL EMERGENCY FORM
20 _____ - 20 _____

Student Name: _____

Address:_____ City_____Zip Code _____

Telephone: _____ Email: _____

Date of Birth:_____

Purpose: To enable parents and guardians to authorize the provision of emergency / treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

RESIDENTIAL PARENT OR GUARDIAN:

Mother's Name: _____ Work Phone: _____
First Last
Cell Phone: _____

Father's Name: _____ Work Phone: _____
First Last
Cell Phone: _____

Other's Name: _____ Work Phone: _____
First Last
Cell Phone: _____

If I cannot be contacted, and it is advisable to send my child home due to minor illness or injury, my child can be released in the custody of the following relative(s) or childcare provider(s):

(!) Name: _____ Relationship: _____

Address: _____ Daytime Phone: _____

City: _____ Cell Phone: _____

(2) Name: _____ Relationship*:* _____

Address: _____ Daytime Phone: _____

City: _____ Cell Phone: _____

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PART I OR II MUST BE COMPLETED

PART I: To Grant Consent

I hereby give consent for the following medical care providers and local hospital to be called:

PHYSICIAN: _____ Phone: _____

DENTIST:_____ Phone: _____

MEDICAL SPECIALIST:_____ Phone: _____

LOCAL HOSPITAL: _____ EMERGENCY ROOM 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:

Dr._____ or Dr._____
(preferred doctor) (preferred dentist)

in the event the designated preferred practioner is not available, by another licensed physician or dentist, and (2) the

transfer of the child to _____ (preferred hospital) or any hospital reasonably accessible.

*This authorization does not cover major surgery unless the medical options 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 of Parent / Guardian_____ Date: _____

_____
Address City Zip Code

PART II: Refusal to Consent

*I **do not** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring treatment, I wish the school authorities to take the following action:*

_____
_____
_____

Signature of Parent / Guardian_____ Date: _____

_____
Address City Zip Code