STS. PETER & PAUL SCHOOL

Ottawa-Glandorf School District

EMERGENCY MEDICAL
AUTHORIZATION
FORM 5341

Student Name_____

Date of Birth_____

Home Address_____

Please check if this is a new address from previous school year. ☐

Home Phone_____

Please check if this is a new number from previous school year. ☐

E-Mail Address_____

Grade Level/Homeroom_____ School Year_____

CONTACT INFORMATION

Custodial Parent(s)_____

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.
Please number in order of who should be called first, second and third.

			Home	*Work*	*Cell*
____ Mother's Name	Work Place	Daytime Phone	☐	☐	☐
____ Father's Name	Work Place	Daytime Phone	☐	☐	☐
____ Other's Name	Work Place	Daytime Phone	☐	☐	☐

Name of relative or childcare provider to be contacted in the event parents cannot be reached: (please list at least two)

			Home	*Work*	*Cell*
____ Name	Relationship	Daytime Phone	☐	☐	☐
____ Name	Relationship	Daytime Phone	☐	☐	☐
____ Name	Relationship	Daytime Phone	☐	☐	☐

LEGAL CUSTODY

If this is a divorced and separated home, list below the Court Docket Number which gives the name of the person(s) having legal custody: (must have a copy on file)

Docket Number_____ State of_____ Copy on File: Yes_____ No_____

Date of Docket_____ Person(s) having legal custody_____

If not living with person of legal custody, state name of person with whom child is living:

Name_____ Relationship_____

Address_____

PERMISSION

FIELD TRIP PERMIT

My student has permission to go with a school chaperoned group on field trips away from the building.

*Signature of Parent/Guardian*_____ *Date*_____

PUBLICITY PERMIT/CLASS ROSTER

Sts. Peter & Paul School has permission to use my child's name and photograph in any school-related news release to local and area newspapers and to make available, upon request, student directory information. Permission is also granted for school-related photographs/videos of my child to be posted on the school's website and/or viewed on school's closed-circuit television. (Full name will not be used.)

*Signature of Parent/Guardian*_____ *Date*_____

PART I OR II MUST BE COMPLETED

PART I

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

Doctor	Phone
Dentist	Phone
Optometrist	Phone
Medical Specialist (if needed)	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 above-named doctor, 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 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 prior to the performance of such surgery.

Please list facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which the schools should be alerted:

Allergies (bee stings, foods, etc.)_____

Medications Taken_____

Physical Impairments_____

Asthma_____

Seizures_____

Diabetes_____

Names of other children in your family:

_____

*Signature of Parent/Guardian*_____ *Date*_____

or

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 emergency treatment, I wish the school authorities to take no action; or to:_____

_____

*Signature of Parent/Guardian*_____ *Date*_____

ATHLETIC INSURANCE

FOR JUNIOR HIGH ATHLETES ONLY - ATHLETIC INSURANCE

____ My child does **not** plan to participate in any athletic program sponsored by Sts. Peter and Paul School.

____ My child plans to participate in athletics sponsored by Sts. Peter and Paul School and has permission to participate in the following sport(s):_____

We understand that our child must be covered by insurance to participate. In the event of an injury, we will cover the medical expenses as follows:

____ We have family insurance provided by _____. The policy number is _____.

We understand that we are responsible for all excess costs above and beyond what the insurance will not cover and that the school does not carry any insurance on student athletes. We also give permission for the school person in charge to determine when our child should be taken for emergency medical treatment. We have instructed our student athlete to report all injuries to the person in charge immediately.

*Signature of Parent/Guardian*_____ *Date*_____