ST. GABRIEL CONSOLIDATED SCHOOL

Emergency Card

Student Name_____ Grade_____

Address_____

City_____ Zip Code_____

Telephone Number_____ Birthdate_____

Father/Guardian's Name_____

Address (if different from above)_____

Home Telephone Number_____ Work Telephone Number_____

Cellular Number_____

Place of Employment_____

Mother/Guardian's Name_____

Address (if different from above)_____

Home Telephone Number_____ Work Telephone Number_____

Cellular Number_____

Place of Employment_____

In the event this student becomes ill at school but does not need medical attention,
Name two people to be contacted if you cannot be reached:

Name_____ Telephone_____

Is this person a neighbor or a relative_____

Name_____ Telephone_____

Is this person a neighbor or a relative_____

PLEASE COMPLETE BOTH SIDES

EMERGENCY MEDICAL AUTHORIZATION

St. Gabriel Consolidated School

Student Name _____ Date of Birth _____

Grade _____ Teacher _____

Address _____ City _____ State _____ Zip _____ Telephone _____

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

A. Residential Parent/Guardian

Mother's Name _____ Daytime Phone Number _____ Cell _____

Father's Name _____ Daytime Phone Number _____ Cell _____

Other Name/Relationship _____ Daytime Phone Number _____

B. Name of Relative or Childcare Provider _____ _____

Name Relationship

_____ _____

Address Phone Number

********** PART I *OR* PART II MUST BE COMPLETED AND SIGNED **********

PART I MUST BE COMPLETED TO GRANT CONSENT: I HEREBY GIVE CONSENT FOR THE FOLLOWING MEDICAL CARE PROVIDERS/LOCAL HOSPITAL TO BE CALLED	
Doctor's Name	Phone Number
Dentist's Name	Phone Number
Medical Specialist	Phone Number
Local Hospital	Emergency Room Phone Number

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 reasonable 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.

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

_____

_____

_____

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

Address _____

DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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 the following action.

_____

_____

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

Address _____