St. Alphonsus & St. Joseph PSR 2018-2019

EMERGENCY MEDICAL AUTHORIZATION/PERMISSION FORM

Phone number where a parent can be reached during PSR hours_____

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

Name of Relative or Childcare Provider FOR EMERGENCY CONTACT:

_____Relationship_____

Phone: _____alternate phone: _____

TO GRANT CONSENT:

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

Physician: _____Phone:_____

Dentist: _____ Phone: _____

Hospital: _____ 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 doctors, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist;
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 any pertinent facts concerning the child's medical history to which we and a physician should be alerted:

ALLERGIES: _____

MEDICATIONS: _____

SPECIAL NEEDS: _____

OTHER MEDICAL INFO: _____

PERMISSION RELEASE for my child's picture to be taken and used in brochures, video, CD/DVD's websites etc. for publicity use only.

____I grant permission ____I do NOT grant permission

Date_____ Signature of Parent of Guardian_____