ST. ALBERT THE GREAT SCHOOL
104 W. DOROTHY LANE
KETTERING, OH 45429

EMERGENCY MEDICAL AUTHORIZATION FORM

Student Name_____Grade_____Birth Date_____

Address_____

Home Phone_____ Email Address_____

List the name of the person(s) who has custody of student:_____

Mother's Name_____(day#)_____(cell #)_____

Father's Name_____(day#)_____(cell #)_____

In case of accident or serious illness, if I cannot be reached at the above, you have my permission to contact the following:

Name_____Relationship_____

Address_____Phone #_____

Family Doctor_____Phone#_____

Emergency Hospital of Choice_____

I give permission for my child to take Ibuprofen: Yes _____ Dosage_____ No _____

I give permission for my child to take Acetaminophen: Yes _____ Dosage_____ No _____

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

_____

_____

Other then the above listed emergency names who else may be picking up your child after school?

_____

_____

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Consent:
I give St. Albert the Great School permission for medical treatment for my child.

Date_____ Signature of Parent_____

Refusal of 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_____