Please give any pertinent information regarding the health of this child:

EMERGENCY CARD
Office of Catholic Schools
Diocese of Columbus

_____
School
School Year 20 ____ - ____

Student's Name _____ Room _____

Address _____

_____ Zip _____

Phone _____ Birthdate _____

Father/Guardian's Name _____

Address _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone/Pager _____

Email _____

Place of Employment _____

Mother/Guardian's Name _____

Address _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone/Pager _____

Place of Employment _____

Email _____

In the event this student becomes ill at school but does not need medical attention, name three people, i.e., relative, neighbor, child care provider, to be contacted if you cannot be reached.

1. _____ Relationship _____ Phone _____

2. _____ Relationship _____ Phone _____

3. _____ Relationship _____ Phone _____

(See reverse side and inside of card.)

EMERGENCY MEDICAL AUTHORIZATION

(State of Ohio Revised Code Section 3313.712)

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.

PART I OR PART 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 above-named doctors, 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.

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

_____

_____

Date _____ Signature of Parent/Guardian _____

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 _____