Corpus Christi Academy
5655 MAYFIELD ROAD
LYNDHURST, OHIO 44124
(440) 449-4244

EMERGENCY MEDICAL AUTHORIZATION
2019-2020 SCHOOL YEAR

Family Name:_____ First Name:_____ Middle Name:_____

Sex: (circle) M F Grade Level:_____ Date of Birth:_____

Business Phones: (Father):( )_____ (Mother): ( )_____

Cell Phones: (Father):( )_____ (Mother): ( )_____

Address:_____ City:_____ Home Phone: ( )_____

Mother or Guardian:_____ Occupation:_____ With Family:_____

Father or Guardian:_____ Occupation:_____ With Family:_____

IF I CANNOT BE CONTACTED and it is advisable to send my child home due to minor illness, injury or emergency, my child can be released in the custody of:

Name:_____ Address:_____ Phone:_____

Name:_____ Address:_____ Phone:_____

Name:_____ Address:_____ Phone:_____

***Must show proof of identification to be able to release said student.**

Date:_____ Signature of Parent or Guardian:_____

FACTS CONCERNING THE CHILD'S MEDICAL HISTORY INCLUDING ALLERGIES, MEDICATIONS BEING TAKEN, AND ANY PHYSICAL IMPAIRMENTS TO WHICH A PHYSICIAN SHOULD BE ALERTED. PLEASE INCLUDE GLASSES/CONTACTS, ORTHODONTIC APPLIANCES OR MEDICATIONS TAKEN AT HOME.

_____
_____
_____
_____
_____
_____

Date:_____ Signature of Parent:_____

Transportation: (please check one) Bus_____ Walk_____ Parent Pick-Up_____

If your child does not go directly home after school, please list where the child goes, on what days, with phone numbers.

Name_____Phone Number_____ M T W TH F

CONTINUE TO BACK OF THIS PAGE TO COMPLETE FORM

Please provide your child's medical-care provider information below:

Doctor: Name:_____

Address:_____

Phone No.: ( )_____

Dentist: Name:_____

Address:_____

Phone No.: ( )_____

PRIVACY ACT: It is understood that no student information will be given out without parental consent. However, we wish to inform you that your name and home phone number will be given to selected adults who will keep the information confidential and will use it only to inform you of emergency situations. This procedure will replace our old method of informing parents of an emergency school closing. If you have any problem with this policy, please call me in the school office at (440) 449-4242.

I have read the above statement regarding the Privacy of Student Information.

Date:_____ Signature:_____

PART I OR II MUST BE COMPLETED

PART I (TO GRANT CONSENT)

In the event reasonable attempts to contact me at: ( )_____ or _____
(phone) (other parent)
at ( )_____ have been unsuccessful, I hereby give my consent for:(1) the administration of any treatment deemed necessary by Dr._____, or Dr._____ or in the
(dentist) (physician)
event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to:_____ hospital or any hospital reasonably accessible. **This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentist, concurring in the necessity for such surgery, are obtained before surgery is performed.**

Date:_____ Signature of Parent or Guardian:_____

PART II (REFUSAL TO CONSENT)
DO NOT COMPLETE PART II IF YOU COMPLETED PART I

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:_____
_____

Date:_____ Signature of Parent or Guardian:_____