St. Nicholas School
Emergency Medical Authorization

Please Print

_____ _____
(Name of student) (Student Address)

_____ _____ _____
(City) (State) (Zip)

_____ _____ _____ _____ _____
(Grade) (Room) (Birth Date) (Bus number assigned) (Family email address)

NAME of **Public Elementary** or **Middle School** student would attend if not at St. Nicholas _____

PERSON(S) TO BE NOTIFIED IN CASE OF EMERGENCY:

_____ _____ _____ _____
(Mother's Name) (Home phone#) (Father's Name) (Home phone #)

_____ _____ _____ _____
(Cell Phone) (Work phone) (Cell phone) (Work phone)

_____ _____
(Place of Employment) (Place of Employment)

ADDITIONAL CONTACTS IF PARENTS CANNOT BE REACHED:

_____ _____ _____
(Name) (Phone) (Relationship)

_____ _____ _____
(Name) (Phone) (Relationship)

_____ _____ _____ _____
(Family Physician) (Phone) (Family Dentist) (Phone)

_____ _____
(Preferred emergency center or hospital) (Phone)

MEDICAL HISTORY

Please list all pertinent facts concerning the student's medical history including allergies, medications, and physical impairment: _____

_____

MEDICATION ALERT: Students requiring medicine during the school day will report to the school nurse. **NO MEDICATION WILL BE ADMINISTERED** without a completed authorization form from the student's physician and parent. This includes all non-prescription medication.

PART 1 – TO GRANT REQUEST

If we or the authorized physician named above cannot be reached at the time of an emergency and if immediate observation or treatment is urgent, we hereby authorize and direct the school authority to send the child, properly accompanied to the emergency center/hospital or the physician most easily accessible.

_____ _____
Parent/Guardian Signature Date

DO NOT COMPLETE PART 2 IF YOU COMPLETED PART 1

PART 2 – 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 TAKE NO ACTION.

_____ _____
Parent/Guardian Signature Date