THE CALVARY ACADEMY
11970 KENN ROAD
CINCINNATI, OHIO 45240
513-674-9600
513-674-9602 fax

EMERGENCY CONTACT AND MEDICAL AUTHORIZATION

____ ____________
Student's full name (please print) Grade

In an emergency please contact ____________________(__________) at ____________
Name Relationship Phone number

____________________(__________) at ____________
Name Relationship Phone number

____________________(__________) at ____________
Name Relationship Phone number

Purpose – To enable parents to authorize emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached or are unable to respond in a timely manner.

Please complete Part I or Part II (Part II on opposite side)

Part I
In the event reasonable attempts to contact the above have been unsuccessful or although contacted the response time will be lengthy, I hereby give my consent for (1) the administration of any treatment deemed necessary by a preferred physician or preferred dentist or in the event that the designated preferred practitioner is not available, by another licensed physician or dentist: and (2) the transfer of the child to the preferred hospital or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Preferred Physician ______________________________ Phone# ____________

Preferred Dentist ______________________________ Phone# ____________

Preferred Hospital ______________________________

Any facts concerning the student's medical history including allergies, medications, and any physical impairments to which a physician should be alerted, (additional space available on back of form).

____
____

________ ______________________ ______________________
Date Signature of Parent Address

Revised 04/25/06
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DO NOT COMPLETE PART II IF YOU COMPLETED PART I

Part II

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 ________________________________

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__________ ____ __________________________
Date Signature of Parent Address

Continue from Part I : facts concerning the student's medical history including allergies, medications, and any physical impairments to which a physician should be alerted__________________________

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