EMERGENCY MEDICAL AUTHORIZATION

_____ _____
Participant's Name Parent or Guardian's Name

_____ _____
Address Phone Number (Home - Business)

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for participants who become ill or injured during their visit to the Pontifical College Josephinum when parents or guardians cannot be reached.

PART I OR II MUST BE COMPLETED
Part I (To Grant Consent)

In the event reasonable attempts to contact me at _____(phone number) or _____(other parent or guardian) at _____(phone number) have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by Dr. _____(preferred physician) at _____(phone number), or Dr. _____ (preferred dentist) at _____(phone number), 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 _____(preferred hospital) or 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 impairment to which a physician should be alerted:

_____

_____
Date Signature of Parent or Guardian Address

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 authorities to take no action or to:

_____

_____
Date Signature of Parent or Guardian Address