

# OUR LADY OF HUNGARY SCHOOL

735 West Calvert Street South Bend, Indiana 46613

## EMERGENCY MEDICAL CARE FORM

Note: Parents must sign either Part I (Consent...) or Part II (Authorization to Notify of Refusal to Consent...) prior to the commencement of each school year for each child enrolled in a Diocesan School. Parents are responsible for updating the information on this form during the school year should changes occur.

### Part I. Consent to Emergency Care

Name of Child: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

In the event of an emergency, I request that the school make reasonable attempts to contact me at \_\_\_\_\_ (phone number) or \_\_\_\_\_ (other parent/adult) at \_\_\_\_\_ (phone number).

**I understand that in an emergency, exigent circumstances may prevent the school from contacting me immediately, or the school may be unable to reach me. I therefore consent to the school taking action which it deems necessary to secure emergency medical care/treatment for my child even if I have not been contacted.**

I understand that decisions concerning the type of emergency medical care or treatment administered are made by health care providers and not by the school and that exigent circumstances may require the administration of emergency medical care or treatment without my prior consent. However, I have indicated below any treatment preferences I have for my child which the school may disclose to a health care provider. (Parents/guardians may check and complete any of the following):

\_\_\_\_\_ Dr. \_\_\_\_\_ is my preferred physician and Dr. \_\_\_\_\_ is my preferred dentist.

\_\_\_\_\_ \_\_\_\_\_ is my preferred hospital.

\_\_\_\_\_ Receipt of my consent prior to my child receiving major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

\_\_\_\_\_ Other:

The school may also disclose the following checked information to a health care provider:

\_\_\_\_\_ Insurance Information: Insurance Company Name \_\_\_\_\_  
Policy/Group/Claim No. \_\_\_\_\_

\_\_\_\_\_ The following information regarding allergies my child has, medication my child is taking, and other medical facts about my child:

I understand that in the event of an emergency, the school will make reasonable efforts to notify a health care provider of the above-checked information, but I acknowledge that I am responsible for communicating such information to the appropriate medical personnel.

Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_

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### Part II. Refuse to Consent to Emergency Medical Care

Name of Child: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_

In the event of an emergency, I request that the school make reasonable attempts to contact me at \_\_\_\_\_ (phone number) or \_\_\_\_\_ (other parent/adult) at \_\_\_\_\_ (phone number).

I understand that decisions concerning the administration of emergency care or treatment are made by health care providers and not the school. I do NOT want emergency medical treatment or care administered to my child. In the event of an emergency, I authorize the school to inform any health care providers of my wishes. While I understand that the school will make reasonable efforts to contact me and/or notify a health care provider of my wishes prior to the administration of any emergency medical care or treatment, I understand that exigent circumstances may prevent this. I also understand that I, not the school, am responsible for communicating my wishes to the appropriate medical personnel.

\_\_\_\_\_ Date \_\_\_\_\_ Parent/Guardian Signature \_\_\_\_\_