Emergency Card
Office of Catholic Schools
Diocese of Columbus
St. Vincent de Paul
School Year 20 -

Student Name: _____

Address :_____ Zip: _____

Phone: _____ Birthdate: _____

Father/Gaurdian's Name: _____
Address: _____ **Zip: _____**
Home Phone: _____ **Work Phone**: _____ **Cell Phone/Pager: _____**
Email: _____
Place of Employment: _____

Mother/Guardian's Name: _____
Address: _____ **Zip: _____**
Home Phone: _____ **Work Phone: _____** **Cell Phone/Pager: _____**
Email: _____
Place of Employment: _____

In the event this student becomes ill at school but does not need medical attention, name three people, i.e. relative, neighbor, childcare provider, to be contacted if you cannot be reached.

1. _____ Relationship: _____ Phone: _____
2. _____ Relationship: _____ Phone: _____
3. _____ Relationship: _____ Phone: _____

Please give any pertinent information regarding the health of this child: _____

Emergency Medical Authorization

(State of Ohio Revised Code Section 3313.712)

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians can not be reached.

PART I OR PART II MUST BE COMPLETED

PART I: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called

Physician: _____ Phone :_____
Dentist: _____ Phone :_____
Medical Specialist: _____ Phone :_____
Local Hospital: _____ Emergency Room Phone: _____

In the event reasonable attempts to contact me have been unsuccessful. I hereby give my consent for (1) the administration or any treatment deemed necessary by above named doctors, or, in the event the designated preferred practitioner is not available by another licensed physician, dentist, and (2) the transfer of the child to any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring on 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 impairments to which a physician should be alerted: _____

Date: _____ Signature: _____

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 school authorities to take the following action. _____

Date: _____ Signature: _____