

# Benedictine High School

## Emergency Medical Authorization / Consent To Treat

Student Name \_\_\_\_\_ Birth date \_\_\_\_\_ Grade \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

City \_\_\_\_\_ Zip \_\_\_\_\_

**Parent/Legal Guardian:** Who is the residential parent?     Mother     Father     Legal Guardian

Mother \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Father \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Legal Guardian \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Other emergency contacts when parent(s) or guardian cannot be reached:**

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

Name \_\_\_\_\_ Phone \_\_\_\_\_ Relation \_\_\_\_\_

**Emergency Medical Authorization: Please check Grant Consent or Refusal.**

Purpose: To enable parents to authorize emergency treatment for the above named student who may become ill or injured under school authority, when parents cannot be reached.

**I GRANT CONSENT, I hereby give consent for the following medical care providers and hospital to be called:**

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Hospital \_\_\_\_\_ Phone \_\_\_\_\_

Other Medical Specialist \_\_\_\_\_ Phone \_\_\_\_\_

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

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

\* Facts concerning the medical history of my child including allergies, current medications and any physical impairments to which a physician should be alerted;

\_\_\_\_\_  
\_\_\_\_\_

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

**(Complete below for Refusal of Consent only)**

**REFUSAL OF CONSENT:** I do not give consent for emergency medical treatment for my child. In the event of an illness or injury requiring emergency treatment or attention, I wish the school authorities to take the following action:

\_\_\_\_\_  
\_\_\_\_\_

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

# Benedictine High School Insurance Waiver

*(Please Print)*

Student Name \_\_\_\_\_ Grade \_\_\_\_\_

Purpose: Every student-athlete must present a completed Insurance Waiver form in order to practice or participate in interscholastic athletics or activities. Students participating in interscholastic athletics ***will not*** be covered by the school insurance.

*IT IS OUR UNDERSTANDING THAT BENEDICTINE HIGH SCHOOL, THE FACULTY AND STAFF, ATHLETIC DEPARTMENT, OR THE BOARD OF TRUSTEES WILL NOT ASSUME RESPONSIBILITY OR OBLIGATIONS FOR ANY MEDICAL BILLS OR DEBTS RESULTING FROM ANY INJURY TO THE ABOVE NAMED STUDENT WHILE PRACTICING OR PARTICIPATING IN ANY PRACTICE SESSION, SCRIMMAGE, CONTEST OR ACTIVITY.*

**Please check the appropriate space below;**

We have private insurance for the above named student.

Name of insurance Company \_\_\_\_\_

Policy Number \_\_\_\_\_

Parent/Legal Guardian \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

We ***do not*** have private insurance for the above named student and agree to the above statements of responsibility.

Date \_\_\_\_\_ Signature of Parent/Legal Guardian \_\_\_\_\_

*(Please complete the Emergency Medical Authorization on reverse side)*