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_____

0409

(Please complete Insurance Waiver on reverse side)

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)