

EMERGENCY MEDICAL AUTHORIZATION

The purpose of this form is to make it possible for parents and guardians to authorize the provision of emergency treatment for their children who become ill or injured while under the OLR Summer Day Camp Program authority **when parents or guardians cannot be reached for the purpose of giving consent for such treatment.** Such is necessary to overcome legal obstacles to the provision of such treatment when all reasonable attempts to reach parents or guardians have failed. You authorize such emergency treatment for your child by completing this form.

I, _____, of _____ am the
(your name) (your address)

_____ of _____, a minor, of
(mother, father, etc) (child's name)

_____, who attends the OLR Dayton Summer Day Camp Program.
(child's address)

I hereby give my consent, in the event that all reasonable attempts to contact me at: _____
(phone #)

or _____ have been unsuccessful, for:
(phone #)

1) the administration of any treatment deemed necessary by Dr. _____
(preferred doctor)

or Dr. _____, or in the event that the appropriate preferred practitioner is
(preferred dentist)

not available, by another licensed physician or dentist and

2) the transfer of my child to _____ or any hospital reasonably accessible.
(preferred hospital)

This authorization does not cover major surgery unless the medical opinions of the other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

The following information is needed by any hospital or practitioner not having access to the child's medical history:

Allergies:

Medications being taken:

Physical impairments:

Date of last Tetanus shot:

I will not hold Our Lady of the Rosary School or the Summer Day Camp staff responsible should any accident or injury occur.

Signed _____

Date _____

Witness _____

Date _____