Authorization for Emergency Medical Treatment

This authorization and consent shall be effective for the school year commencing in Aug./Sept. 2024.

I, the undersigned, am the parent/legal guardian of _____, a St. Mary's School student, who resides with me at the address shown hereinafter, and who attends St. Mary's School, 225 6th Street, Tracy MN 56175.

I hereby give my consent, in the event all reasonable attempts to contact me at _____ (phone no.- H, W, C) or _____ (W, C), or (other parent or guardian) at _____ (phone no. - H, W, C), have been unsuccessful, for:

(1) A staff member of the aforesaid school to request medical or dental assistance or treatment for my child which may be necessitated by virtue of participation in a school-sponsored or related activity;
(2) The administration of any treatment deemed necessary by Dr. _____ (preferred physician) or, Dr. _____ (preferred dentist), or in the event the appropriate preferred practitioner is not available, by another licensed physician or dentist;
(3) Medical coverage _____
Policy # _____, no coverage _____;
(4) The transfer of the student to Sanford Tracy Medical Center, 251 5th St. E., Tracy MN, or any hospital reasonably accessible.

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

Dated (m/d/y) _____.

_____
Parent or Legal Guardian

_____
_____
Address