



EMERGENCY MEDICAL AUTHORIZATION

PLEASE COMPLETE PART 1 OR PART 2.

This form authorizes Virgin Islands Montessori School to provide emergency medical treatment to children who become ill or injured while under school authority, after all attempts to reach parent/guardian and other emergency contact persons (as listed on the yellow Registration Card) have been unsuccessful.

Child's Name: _____

Home Phone: _____ Parent Work Phone: _____

Parent Cell Phone: _____ Alternate Phone: _____

Other (Friends, Relatives): _____

Part 1

In the event that reasonable attempts to contact myself or other emergency contact persons have been unsuccessful, I hereby give my consent for any emergency treatment deemed necessary for my child by:

Preferred Physician: _____ Phone: _____

Preferred Dentist: _____ Phone: _____

Or, in the event that the preferred practitioner is not available, any treatment deemed necessary by another licensed physician or dentist, and the transfer of my child to Schneider Hospital, St. Thomas. This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists concur in the necessity for such surgery are obtained prior to the performance of such surgery.

Please include information about your child's medical history, including allergies, medications, and any physical impairments that a physician should be informed of: _____

Parent/Guardian Signature: _____ Date: _____

Part 2

I do **not** give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency medical treatment, I wish the school authorities to take no action or to: _____

Parent/Guardian Signature: _____ Date: _____