EMERGENCY MEDICAL AUTHORIZATION (Please Print)

Student's Name ____**Birth Date** ______________ **Grade** _________

Address ____ **Home Phone** ______________

Mother's or Guardian's Name ____ **Cell Phone #** ______________

Email ____

Where Employed ____**Telephone** ___________________ **Ext.** _______

Father's or Guardian's Name ____ **Cell Phone #** ______________

Where Employed ____**Telephone** ___________________ **Ext.** _______

IN CASE OF AN EMERGENCY, PLEASE CALL

(A) First Contact's Name____ **Relationship** ________________

Address ___________________________________ **Work Phone #** ______________ **Home Phone #** ______________

(B) Second Contact's Name____ **Relationship** ________________

Address ___________________________________ **Work Phone #** ______________ **Home Phone #** ______________

In case of accident or serious illness, I request the school to contact me or my designate. If this cannot be done, I authorize the school to call the physician or dentist listed on this card and to follow his/her instructions. If the physician or dentist named cannot be reached, the school may seek medical services that seem necessary. I realize the school does not assume responsibility for the payment of medical expenses.

Signature of Parent or Guardian ____ **Date** ____________________

In the event emergency treatment is needed, I give the Hospital, its authorized personnel and/or Doctor permission to treat my son/daughter as necessary.

Signed: ____ **Date:**___________________

Allergies: ____

Medical problems: ____

Taking Medication: Yes _____ **No** _____

If yes: Type ____ **Reason** __________________________________

(Medication will be administered at school according to current school policies.)

Physician/clinic: ____ **Phone:**________________

Dentist: ______________________________ **Hospital Preference:** _______________________ **Phone:**________________

OR

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

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Signature of Parent or Guardian ____ **Date** ____________________