

**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 \_\_\_\_\_

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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:

\_\_\_\_\_  
Signature of Parent or Guardian \_\_\_\_\_ Date \_\_\_\_\_