EMERGENCY MEDICAL AUTHORIZATION PERMIT

Whenever my child is involved in a school activity and I am unavailable or otherwise unable to provide authorization directly, I grant to the attending emergency medical technicians and appropriate hospital personnel, the authority to act for me and to provide any required consents and authorization for the delivery of emergency medical care, diagnoses, and treatment, including surgical intervention, if necessary, on behalf of my minor child listed below and to do all other necessary things as I might or could do to provide for my child's health and safety, if I were present.

This authorization is valid for the current school year or until such time as I withdraw the authorization.*

Child's Name_____
(Last) (First)

School_____Grade_____Social Security Number_____

Birthdate_____Sex_____Home Telephone_____

Parent or Guardian name(s)_____

Home Address_____

Mother's Employment_____Telephone_____

Father's Employment_____Telephone_____

Alternative Person to Contact_____Telephone_____

Doctor Preferred_____Telephone_____

Doctor's Address_____

Dentist Preferred_____Telephone_____

Dentist's Address_____

Insurance Company_____I.D. No._____

Important Medical Information

Allergies_____

Current Medications or Treatments_____

_____

Previous Operations or Hospital Confinements_____

_____

_____

Other_____

*Failure to provide authorization may result in your child being denied treatment by medical staff if you cannot be reached in the case of a medical emergency.

Authorized Signature_____Date_____
Parent/Guardian