

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 school principal or his/her designee 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 the 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 _____

School _____ Grade _____ Teacher _____

Birthdate _____ Sex _____ HomePhone# _____

Parent/Guardian _____ Cell phone _____

Home Address _____

Father's employment _____ Work phone _____

Mother's employment _____ Work phone _____

Emergency contact _____ Relationship _____ Phone _____

Emergency contact _____ Relationship _____ Phone _____

Local physician preferred _____ Phone _____

Hospital preferred _____

Insurance Company _____ ID No. _____

Important Medical Information

Allergies _____

List All Current Medications _____

List all Medical Diagnoses and/or Chronic illnesses _____

Other _____

Authorized _____ Date _____

Signature of parent/guardian