Emergency Medical Authorization Permit for Treatment of a Minor Child

If my child is ever injured or seriously ill during school or any school activity and I am unavailable or otherwise unable to provide authorization, I do hereby 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 treatments, including surgical intervention, if necessary, on behalf of my minor child listed below and to do all the necessary things I might or could do to provide for the child's health and safety, if I were present.

Every effort would be made to locate the parent/guardian before any of the above would be implemented.

Please complete the following information thoroughly and contact the school immediately if any of the information changes.

Student's Name: _____

Address: _____ **Grade:** _____

DOB: _____

City, State, Zip: _____ **Sex:** _____

Parent/Guardian name: _____ Home #: _____

Mother's Cell #: _____ Mother's Work #: _____

Father's Cell #: _____ Father's Work #: _____

Other emergency contact: _____ Contact #: _____

Other emergency contact: _____ Contact #: _____

Doctor's name: _____ Phone #: _____

Doctor's address: _____

Dentist's name: _____ Phone #: _____

Dentist's address: _____

Preferred Hospital: _____

IMPORTANT MEDICAL INFORMATION

Drug or other allergies: _____

Pre-existing health concerns: _____

Current Medications: _____

Date of last tetanus injection: _____

_____

Parent/Guardian Signature 14-15

_____

Parent/Guardian Signature 15-16