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.

Authorized_____ Date _____
Parent/Guardian

Child's Name_____
(Last) (First) (Middle)

School_____Grade_____Teacher_____

Birthdate_____ Sex_____ Telephone (area code)_____

Parent or Guardian Names_____

Home Address_____
(Street) (Apt. No.) (City) (State) (Zip)

Mother's Place of Employment_____ Work Phone No._____

Father's Place of Employment_____ Work Phone No._____

Doctor Preferred _____
(Doctor) (Phone No.)

Doctor's Address_____

Dentist Preferred_____
(Dentist) (Phone No.)

Dentist's Address_____

Insurance Company _____
(Insurance Identification No.)

Important Medical Information

Allergies_____

Current Medications or Treatments_____

_____

Previous Operations or Hospital Confinements_____
_____
_____

AUTHORIZED: _____ _____
(Date)