## **EMERGENCY MEDICAL AUTHORIZATION FORM**

**PURPOSE**: To enable parents or guardians to AUTHORIZE emergency treatment for children who become ill or injured while under school authority, when parents cannot be reached. Upon completion, parents must return this form to the school. The original form and any copies thereof may be used to identify the medical options of the undersigned parent.

School District	School Building			Home Room Teacher		Grade
Student's Full Name	Last	First	Middle	Ş	Social Security #	
Student's Address	Street/Road	·	P.O. Box/Apt.#	City	Zip Code	
Student's Birth Date			·	•	•	
Mother's Full Name				_ Daytime Phone (	)	
Father's Full Name				Daytime Phone (	)	
Guardian or Child Care	Provider			Daytime Phone	e( )	
Guardian or Child Care		Street/Ro	ad	P.O. Box/Apt.#	City	Zip
1. Name			•		•	
		INSURA	NCE INFO	RMATION		
Student's Insurance (primary)				ID Number		
		TC	GRANT CONS	SENT		
In case of any emerge the following medical and customary medic Doctor	care providers a al and health care	ind hospital, e deemed ne	and authorize cessary:	these providers an	d hospital to give	any reasonabl
Dentist				Phone (	)	
Nurse Practitioner/Physician Assistant				Phone (	)	
Hospital				Phone (	)	
If, for any reason, the a medical care of my chil major surgery unless or	d to any appropria	te medical ca	are provider, hos			
Nothing in this section attempts to comply with						o, in good faitl
Signature of Parent/Gu	of Parent/Guardian			Date		