

# MEDICAL EMERGENCY AUTHORIZATION FORM 2023-2024

The **Orange-Ulster BOCES** Special Education Program must have parental permission to provide emergency medical treatment to your child in the event an accident occurs during school hours. This form will be used **only** if a parent or the adult(s) listed below cannot be reached. **Orange-Ulster BOCES** student accident insurance pays only for costs **NOT** covered by your family insurance. Your health insurance policy number will be needed by the hospital before your child can be treated. Please provide the information below promptly so that we can provide medical attention as quickly as possible in the event of an emergency. Please call the **BOCES** Health Office if you have any questions. Thank you.

**Student:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **District:** \_\_\_\_\_

(City)

(State)

(Zip Code)

**\* In case of emergency, please list the order in which you would like us to contact the following \***

1 <sup>st</sup> Person Contacted	Parent/Guardian	Relationship to student	Telephone by order of preference	Home/Work/Cell
			1)	
	Contact lives with student? <input type="checkbox"/> Yes <input type="checkbox"/> No		2)	
			3)	

**E-Mail:** \_\_\_\_\_

2 <sup>nd</sup> Person Contacted	Parent/Guardian	Relationship to student	Telephone by order of preference	Home/Work/Cell
			1)	
	Contact lives with student? <input type="checkbox"/> Yes <input type="checkbox"/> No		2)	
			3)	

**E-Mail:** \_\_\_\_\_

3 <sup>rd</sup> Person Contacted	Other	Relationship to student	Telephone by order of preference	Home/Work/Cell
			1)	
	Contact lives with student? <input type="checkbox"/> Yes <input type="checkbox"/> No		2)	
			3)	

**E-Mail:** \_\_\_\_\_

**Health Care Provider:** \_\_\_\_\_ **Phone No.:** \_\_\_\_\_

**Medication (Include name, dosage, time):** \_\_\_\_\_

**Medical Conditions/Problems:** \_\_\_\_\_

**Allergies (asthma, etc.):** \_\_\_\_\_

**Special Equipment:** \_\_\_\_\_

**Private Medical Insurance (name, policy number):** \_\_\_\_\_

**Medicaid Medical Insurance (name, policy number):** \_\_\_\_\_

My signature below authorizes Orange-Ulster BOCES to release my child's confidential information to school staff or other persons who have a need to know: teacher, principal, nurse, school district transportation director and school bus driver as needed, to provide safe transport to and from school. All other student information and records will be kept in a confidential manner and will not be released without written authorization of parents or guardians.

**Parent/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_