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 _____
Signature of Parent/Guardian

Child's Name _____
(Last) (First) (Middle)

School _____ Grade _____ Teacher _____

Birthdate _____ Sex _____ Telephone _____

Parent or Guardian Names _____

Home Address _____

Mother's Employment _____ Telephone _____

Father's Employment _____ Telephone _____

Doctor Preferred _____ Telephone _____

Doctor's Address _____

Dentist Preferred _____ Telephone _____

Dentist's Address _____

Insurance Company _____I.D. No._____

Important Medical Information

Allergies _____

Current Medications or Treatments _____

_____

Previous Operations or Hospital Confinements _____

_____

Other: _____