AUTHORIZATION FOR EMERGENCY CARE

This form is to be completed and returned directly to the school nurse.

CHILD _____ DOB _____ SEX ___ M or ___ F
(LAST NAME) (FIRST NAME) MI

LIST ALL SPECIAL MEDICAL CONDITIONS FOR THIS CHILD:

_____
_____
_____
_____

PARENT/GUARDIAN:

NAME _____ Home Phone _____ Cell Phone _____

ADDRESS _____

PRIMARY PHYSICIAN:

NAME _____ Phone _____

DENTIST:

NAME _____ Phone _____

HOSPITAL PREFERENCE:

NAME _____

INSURANCE PLAN _____ MEMBER # _____

OTHER EMERGENCY CONTACT PERSONS:

NAME _____ Home Phone _____ Cell Phone _____

Relationship to child _____

NAME _____ Home Phone _____ Cell Phone _____

Relationship to child _____

I understand that in the event of serious accident or illness to the above named child requiring immediate attention every effort will be made to contact the adults listed above. If none of the above persons can be contacted, I hereby authorize school personnel to seek whatever medical attention is deemed necessary where it is available. I authorize the attending physician and/or other medically trained personnel to render necessary emergency treatment. I also agree to pay all expenses incurred for services rendered to the above named child.

Otherwise, I expect to be notified of serious accident or illness at once to the above named child and will make my own arrangements for medical care for my child.

Signature of Parent/Guardian _____ Date _____

Signature of Witness _____

Original = School Health Office **Copy = School Administrative Office**