



**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 \_\_\_\_\_