Student # _____

Student's Name: _____ Birthdate: _____
(Last) (First) (Middle)

Address: _____ Grade: _____
(Street) (City) (Zip)

Home Phone: _____ Email: _____

EMERGENCY AUTHORIZATION

To be filled out and returned to school EACH year.

1. In the event of illness or injury, I hereby authorize school officials on my behalf to obtain emergency transportation and treatment.

Name of family physician: _____ Phone: _____ Medical Insurance: _____

2. _____
Father/Guardian Work/Cell Phone

3. _____
Mother/Guardian Work/Cell Phone

If I (we) cannot be reached, please call:

_____
(Relative, friend, neighbor) Phone

_____
(Relative, friend, neighbor) Phone

List of other students in this school (Brother, Sister, Cousin).

_____

_____

Please describe any chronic health condition, surgery, illness, injuries or medications which are important for the school nurse to know about.

_____

_____

The school district cannot assume responsibility for payments of physician's fees, ambulance transportation, etc. PLEASE NOTE: A STUDENT ACCIDENT POLICY IS AVAILABLE to all students for a nominal fee. Promptly report change of address, phone number, or name of doctor to the Health Office.

DATE _____ SIGNATURE OF PARENT OR GUARDIAN _____