

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: \_\_\_\_\_