AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

STUDENT NAME_____
DATE_____GRADE _____ DOB_____
ADDRESS_____
HOME PHONE_____WORK/CELLPHONE_____
EMERGENCY CONTACT_____

LIST ALL PERSON(S) WITH PERMISSION TO PICK YOUR CHILD UP FROM SCHOOL, PLEASE INCLUDE PHONE NUMBERS

_____
_____
_____

HEALTH INFORMATION:
ALLERGIES_____

MEDICAL CONDITIONS_____
_____

MEDICATIONS TAKEN
DAILY_____
_____

PHYSICIAN(S) NAME(S)_____

IN ACCORDANCE WITH STATE STATUTES, WRITTEN AUTHORIZATION OF THE PARENT OR GUARDIAN OF A STUDENT IS REQUIRED FOR NON-INVASIVE TESTING AND ADMINISTERING MEDICATIONS TO A STUDENT AT SCHOOL. THE FOLLOWING NON-PRESCRIPTION MEDICATIONS ARE USUALLY AVAILABLE IN THE OFFICE OF THE SCHOOL NURSE: TYLENOL, ANTI-ACIDS, COUGH DROPS, AND TOPICAL LOTIONS OR OINTMENTS. PLEASE SIGN BELOW IF ALL MEDICATIONS LISTED ARE APPROPRIATE TO ADMINISTER TO YOUR CHILD IN TIME OF NEED.

PARENT/GUARDIAN_____

IN THE EVENT OF AN EMERGENCY, AT SCHOOL OR SCHOOL ACTIVITY, THE SCHOOL OFFICIALS HAVE MY PERMISSION TO TRANSPORT MY CHILD TO THE NEAREST HEALTH CARE FACILITY FOR THE SAFETY AND WELL BEING OF MY CHILD.

PARENT/GUARDIAN_____