4109.2 (A)

Emergency Medical Authorization Form (Please Print)

Student's Name _____Grade ___ School District_____ Bus # ____

Mother's or Guardian's Name _____Home/Mobile Phone _____

Where employed _____ Telephone _____Ext. ____

Father's or Guardian's Name _____ Home/Mobile Phone _____

Where Employed _____ Telephone_____ Ext. ____

IF ABOVE PARENTS/GUARDIANS CANNOT BE REACHED, PLEASE CALL:

1. **First Contact's Name _____ Relationship_____**
   Address _____
   Work # _____Home/Mobile #_____
2. **Second Contact's Name _____Relationship_____**
   Address _____
   Work # _____Home/Mobile #_____

In case of an accident or serious illness, I request the school to contact me or my designate.

In the event emergency treatment is needed, I give the school permission to call 911 immediately. I, also, give the hospital, its authorized personnel and/or physician permission to treat my son/daughter as necessary.

Signature _____ Date _____

Blood Type_____ Allergies _____

Medical Problems _____

Taking medication Yes _____ No _____

If yes, name of medication_____Reason(s)_____

Physician/Clinic _____Telephone _____

Dentist _____Telephone _____

Medical Insurance Carrier _____

Signature of Parent or Guardian _____