EMERGENCY MEDICAL AUTHORIZATION CARD (PLEASE PRINT) 4109.2(B)

Students' Name & Address	Date of Birth:
	Home Phone:
	Grade:
	Homeroom:

PARENT/GUARDIAN CONTACT INFORMATION

Mother/Guardian:	Home Phone:
	Cell Phone:
Place of Employment:	Work Phone:
Father/Guardian:	Home Phone:
	Cell Phone:
Place of Employment:	Work Phone:

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

First Contact Name & Address:	Relationship:
	Home Phone:
	Cell Phone:
Second Contact Name & Address:	Relationship:
	Home Phone:
	Cell Phone:

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 and it its authorized personnel and physicians permission to treat my son/daughter as necessary.

Signature of Parent/Guardian: _____ Date: _____

Blood Type:	
Allergies:	
Medical Problems:	
Taking Medication: Yes No	If yes, Name:
	Reason:
Physician Name:	Phone Number:
Dentist Name:	Phone Number
Medical Insurance Carrier:	

Signature of Parent/Guardian: _____ Date: _____