

AUTHORIZATION FOR EMERGENCY MEDICAL - STUDENT

This form is required for all trips. Emergency medical card may be used in place of this form.
IMPORTANT: This information must be taken along on the field trip in case of an emergency.

STUDENT	DATE OF BIRTH	Today's Date
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I/We, the parent(s) of legal guardian(s) of above student, hereby delegate to the School System the authority to authorize and consent to any or all medical, surgical, dental, optical, hospital care, or treatment, in case of emergency, while on an educational trip. Such treatment is to be rendered by, or under the jurisdiction of a duly licensed physician or dentist. The School System is fully authorized to act in accordance with best judgment in any such emergency and is absolved from any liability or financial responsibility to connection therewith.

X _____ Home Telephone Number _____
Signature of Parent or Guardian

Home Address _____

 Mother's/Father's Place of Employment Work Telephone Number(s)

 Pager/Cell Phone Number(s)

Medical-Hospital Insurance Co. _____

Name of Subscriber _____

Group No. _____ Service No. _____ Contract No. _____

EMERGENCY INFORMATION

Please list any allergies your child has: _____

Please note any special needs your child has (dietary, medical conditions, etc. You may attach separate sheet.):

 Name of Physician Address Telephone No.

 Name of Dentist Address Telephone No.

 Name of Eye Doctor Address Telephone No.

If unable to contact spouse, please call (local contact):

 Name Address Telephone Relationship