

AUTHORIZATION FOR EMERGENCY MEDICAL - ADULT

This form is desirable but not required for staff or adult supervisors.
IMPORTANT: This information must be taken along on the field trip in case of an emergency.

Name of field trip supervisor	Address & Telephone No	Today's Date

I, a supervisor on this educational trip to (destination) _____ on (date) _____ 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 I am a supervisor. 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 Adult Supervisor

Home Address _____

Spouse Place of Employment, if applicable _____ 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 you have: _____
 Please note any special needs you have (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