

EMERGENCY MEDICAL INFORMATION AND AUTHORIZATION FORM

REQUIRED FOR EACH STUDENT EVERY YEAR – DUE TO OFFICE BY AUGUST 1st

Student's Last Name _____ **First Name** _____ **Grade** _____

Social Sec# _____ Student cell phone # _____ Date of Birth _____

Parents/Guardians
Names _____

Address _____ City _____ Zip _____

Home Phone # _____ Work # _____ Cell# _____

Parent E-mail _____

If parents are separated or divorced, who is the primary residential parent? _____

OtherParent/Guardian: _____

Address _____ City _____ Zip _____

Home Phone # _____ Work # _____ Cell# _____

Persons to be notified in case of emergency and allowed to pick up from school:

Name _____ Relationship _____ Home _____ Cell _____

Name _____ Relationship _____ Home _____ Cell _____

Physician to call in emergency: _____ Phone # _____

Hospital of Choice _____

Current Medications _____

Any known allergies such as medications, bee stings, etc _____

Please place your *INITIALS* next to each medication that may be administered to your child.

Tylenol _____ **Tums** _____ **Ibuprofen** _____

Benadryl _____ **Sudafed** _____

EMERGENCY MEDICAL AUTHORIZATION

Authorization for emergency medical care in event of serious illness or accident if parent(s) cannot be reached:

Signature of Parent or Legal Guardian

Today's Date

Insurance Company

Policy