

**Emergency Medical Authorization Permit for Treatment of a Minor Child**  
**2021 - 2022**

If my child is ever injured or seriously ill during school or any school activity and I am unavailable or otherwise unable to provide authorization, I do hereby grant to the school principal or his/her designee the authority to act for me and to provide any required consents and authorization for the delivery of emergency medical care, diagnoses and treatments, including surgical intervention, if necessary, on behalf of my minor child listed below and to do all the necessary things I might or could do to provide for the child's health and safety, if I were present.

Every effort would be made to locate the parent/guardian before any of the above would be implemented.

Please complete the following information thoroughly and contact the school immediately if any of the information changes.

**Student's Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_ **Sex:** \_\_\_\_\_

Parent/Guardian name: \_\_\_\_\_ Home #: \_\_\_\_\_

Mother's Cell #: \_\_\_\_\_ Mother's Work #: \_\_\_\_\_

Father's Cell #: \_\_\_\_\_ Father's Work #: \_\_\_\_\_

Other emergency contact: \_\_\_\_\_ Contact #: \_\_\_\_\_

Other emergency contact: \_\_\_\_\_ Contact #: \_\_\_\_\_

Doctor's name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Doctor's address: \_\_\_\_\_

Dentist's name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Dentist's address: \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_

**IMPORTANT MEDICAL INFORMATION**

Drug or other allergies: \_\_\_\_\_

Pre-existing health concerns: \_\_\_\_\_

Current Medications: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature