Print Form

PLAIN LOCAL SCHOOLS

EMERGENCY MEDICAL AUTHORIZATION

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannto be reached.

Student Name | **Phone Number** | **Bus Number**

Address, City, State, and Zip | **School Attending**

Date of Birth | **Gender** ○ Male ○ Female | **Grade Level** | **Home Room**

RESIDENTIAL PARENT OR GUARDIAN

Mother | **Daytime Phone**

Father | **Daytime Phone**

Other Name | **Daytime Phone**

Name of Relative or Child Care Provider | **Relationship**

Address | **Phone Number**

I hereby give consent for the following medical care providers and local hospital to be called:

Doctor | **Phone Number**

Dentist | **Phone Number**

Medical Specialist | **Phone Number**

Hospital | **Phone Number**