USD #232

Emergency Medical Authorization

Return this form to the school office.

Student Name _____ Grade _____
Student Address _____ City, Zip _____
Student DOB _____ Age _____

Guardian Information

Mother's Name _____ Home Phone _____
Cell Phone _____
Work Phone _____ Employer _____

Father's Name _____ Home Phone _____
Cell Phone _____
Work Phone _____ Employer _____

Medical Contacts

Doctor _____ Phone _____
Dentist _____ Phone _____
Preferred Hospital _____ Phone _____

Student Medical Information

Allergies _____
Diagnosed Conditions _____
Current Medications _____

Emergency Contacts
If parents cannot be contacted, list two emergency contacts.

Name _____ Home Phone _____
Cell Phone _____ Work Phone _____
Name _____ Home Phone _____
Cell Phone _____ Work Phone _____

I give my permission for emergency medical or dental treatment for my child who may become injured or ill while under school authority. I understand this authorization does not cover any surgery unless the medical opinion of two licensed physicians or dentists concur in the necessity for such surgery and these opinions are rendered and obtained prior to the performance of such surgery.

Parent/Guardian Signature _____ Date _____