Insert School Information Here

# **Emergency Medical Treatment Authorization**

Name of Student:

Parent/Legal Guardian:

Relationship:

Telephone:       Email:

Address:

### In case of emergency, if unable to contact parent/guardian, please contact:

1. Telephone: Relationship:

**2.** Telephone: Relationship:

Student’s Physician: Telephone:

Student’s Dentist: Telephone:

### If student is taking any regularly prescribed medication, is allergic to any medication, or if there is any other emergency information we need to know, please indicate below:

## **ACknowledgement**

In the event of an accident or illness, I hereby grant permission to authorized personnel to provide first aid to my child in the event of an emergency if reasonable attempts to contact those named above prove unsuccessful. I hereby give consent to transport my child to the Emergency Medical Department of the nearest hospital. If the student’s physician cannot be contacted, medical treatment deemed necessary by the attending licensed physician or dentist may be administered.

**Signature of Parent/Legal Guardian:**

**Date:**

### The School District/BOCES does not discriminate on the basis of race, color, national origin, sex, disability, or age in its programs and activities. The compliance officer is Name/Title and is available at the School District/BOCES name, ADDRESS, E-mail and phone number