HS & MS ACTIVITY
EMERGENCY MEDICAL AUTHORIZATION

(Must be filled out and returned <u>BEFORE FIRST DAY</u> of practice or activity)

Name ____ Social Security # ___________________

Address ____ Birth Date ________________________

Father's Name ________________________ Phone: Home __________ Work: _________ Cell: __________

Mother's Name _______________________ Phone: Home __________ Work: _________ Cell: __________

Allergies: ____

Current Medications: ____

Medicines allergic to: ____

Other Medical Information: ____

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Family Doctor ____ Office Phone _________________

Family Dentist ____ Office Phone _________________

Hospital Preference (if available) ____

EMEGENCY ALTERNATIVE CONTACT PERSONS in case parents CANNOT be reached.

Name ________________________________ Phone: Home __________ Work: _________ Cell: __________

Name ________________________________ Phone: Home __________ Work: _________ Cell: __________

TO WHOM IT MAY CONCERN: I the undersigned, being the parent or legal guardian of the above named student, do hereby grant to any hospital, emergency center, doctor, nurse, paramedic, athletic trainer and/or EMT authorization to grant treatment to my child, when accompanied by or escorted to the treating facility by a teacher, coach, coach's aide, or school administrator.

Further, should the attending physician determine after examination that life-saving surgery or other life-saving procedures may be necessary, permission is hereby extended to the above parties to grant same.

Additionally, I agree to hold harmless such personnel and the USD 274 Board of Education by my action of granting said permission. I also understand that USD 274 is not responsible for payment of any medical bills associated with treatment. I declare under penalty of perjury that the above is true and correct.

____ ___________________

Parent/Guardian's Signature **Date**

<u>Photocopies of the above document will be considered the same as the original copy.</u>