

Emergency Medical Authorization Form

Union Local Athletics

Building _____ Grade _____ Homeroom Teacher _____

Student Information

Student Name _____ Student Birth Date _____

Parent/Guardian _____

Student Address _____ Home Phone _____

_____ Cell Phone _____

Health Information

Allergies _____

Preferred treatment for allergies _____

(If this includes medication of any type, please send a supply to the school nurse)

Chronic medical problems _____

Medication taken every day _____

Prior hospitalizations/surgeries _____

Other health information the nurse should know _____

(Please attach note if health history is lengthy)

Contact Information (Should your child become ill at school and we can't reach the parent/guardian)

Please list contact information in the order you would like the calls to be made:

Name	Relationship	Phone Number
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Insurance Information

_____ My child **does not** have insurance _____ My child **does** have insurance.

Name of the insurance company _____ Policy Number _____

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

Physician _____ Phone() _____

Dentist _____ Phone() _____

Emergency Room

Local Hospital _____ Phone() _____

I give permission for school personnel to administer Tylenol or Tums as needed. Yes ___ No ___

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to performance of such surgery.