NORTH WARREN CENTRAL SCHOOL
EMERGENCY MEDICAL AUTHORIZATION

Student's name___________________________________ DOB_______________________

Name of parent or Guardian that student resides with: ____

Father: ____________________________________ Mother: ___________________________________

Address: __________________________________ Address:__________________________________

____ ____

Place of Work: ______________________________ Place of Work:_____________________________

Home Tel. _________________________________ Home Tel. ________________________________

Work Tel. _________________________________ Work Tel. ________________________________

Cell _____________________________________ Cell _____________________________________

Responsible adult we may contact in the event a parent cannot be reached:

Name____

Phone: Home_______________________Work_____________________Cell___________________________

Name____

Phone: Home_______________________Work_____________________Cell___________________________

Medical Information: (write "none" if not applicable)

Medications student is currently taking:____

If this medication (including inhalers) is/will be used during the school day or at school events, a Dr's note must be on file in the school health office.

Please list ***all*** information concerning the child's medical history including asthma, allergies, medical conditions and physical impairments to which a physician should be alerted:

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Family Physician______________________________Phone:_____________________________

Family Dentist________________________________Phone:_____________________________

CONSENT OF PARENT OR GUARDIAN FOR EMERGENCY TREATMENT:

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give my consent for the administration of any treatment deemed necessary by a licensed physician or dentist.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to the performance of such surgery.

Parent's Signature____Date______________________________