UNION SPRINGS CENTRAL SCHOOL DISTRICT

AUTHORIZATION FOR EMERGENCY TREATMENT OF MINORS IN ABSENCE OF THEIR PARENTS OR GUARDIANS

I give permission for my child _____, birth date _____, to receive emergency medical, dental or surgical care in the nearest medical facility, without my presence, in case of an emergency medical situation deemed necessary by the attending physician.

Special medical problems: _____ Allergies: _____

I understand that every effort will be made to contact me and that this form will authorize emergency treatment until I arrive at the medical facility or in the event my presence is impossible.

This form is valid for the duration of enrollment in the middle/high school in the Union Springs School District unless revoked in writing by me.

I UNDERSTAND THE SIGNIFICANCE OF THIS DOCUMENT

FATHER'S NAME _____ HOME PHONE _____
WORK PHONE _____

MOTHER'S NAME _____ HOME PHONE _____
WORK PHONE _____

If I cannot be reached call _____ HOME PHONE _____
WORK PHONE _____

(Relationship to child) _____

FAMILY PHYSICIAN _____ PHONE _____

_____ _____
Signature of parent or legal guardian Date