FOREST CITY REGIONAL
EMERGENCY MEDICAL AUTHORIZATION FORM

Student's Name: _____

Birth Date: _____

Grade: _____

Parent/Guardian's Name: _____

Home Phone: _____

Cell Phone: _____

In the event the parents cannot be contacted please contact: _____

At phone #: _____

ALLERGIES OR SPECIAL INSTRUCTIONS: (include any medication needed during field trip).

1._____

2. _____

3. _____

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and /or for transportation to a hospital emergency room for treatment for any illness or injury.

Preferred physician: _____Phone_____

Preferred hospital:_____

THE ABOVE INFORMATION MAY BE SHARED WITH SCHOOL PERSONNEL, WHO HAVE A NEED TO KNOW.

_____

Signed (Parent or Guardian)