



**EMERGENCY AUTHORIZATION**

LAST NAME \_\_\_\_\_ FIRST \_\_\_\_\_ Date: \_\_\_\_\_

To the designated teachers-in-charge:

In the event, in your opinion, my child requires emergency medical treatment, you have my permission, and I hereby designate you, my agent, to call the following doctors after you have tried to telephone me and have been unsuccessful.

DOCTOR: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_

In the event that your doctor cannot be reached, you have my permissions, and I hereby designate you my agent, to call any regularly licensed physician in the area of the trip itinerary.

I hereby release you from any claim arising out of the doctor's actions and I assume and agree to pay the doctor's charge for any services rendered at the doctor's direction.

PARENT/GUARDIAN SIGNATURE \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_ BUSINESS/CELL PHONE \_\_\_\_\_

Please list below the names of neighbors, relatives or friends who may be contacted if the parent is not available:

Name \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_

Telephone \_\_\_\_\_

Students are not permitted to hold any medication (prescription or over the counter) on the trip. If your child must have medication during the trip, please contact the school nurse at # \_\_\_\_\_ for the necessary forms and instructions.

Check **YES** or **NO**. (If YES, please explain, using other side of sheet if necessary.)

- 1. Does the student have any allergies to medication, foods, etc.?  YES  NO
- 2. Are there any physical conditions of which we should be aware?  YES  NO
- 3. Does your child have an allergic reaction to insect/bee stings?  YES  NO

If you have one: Blue Cross/Blue Shield # \_\_\_\_\_

Other Insurance Company # \_\_\_\_\_ Policy # \_\_\_\_\_

**(\*For other than Blue Cross/Blue Shield, please attach claim form)**