Evansville Vanderburgh School Corporation

EMERGENCY MEDICAL AUTHORIZATION PERMIT

Whenever my child in involved in a school activity and I am unavailable or otherwise unable to provide authorization directly, I grant the school principal and his/her designee the authority to act for me and to provide any required consents and authorization for the delivery of emergency medical care, diagnosis and treatment, including surgical intervention, if necessary, on behalf of my minor child listed below and do all other necessary things as I might or could do to provide for the child's health and safety, if I were present.

This authorization is valid for the current school year or until such time as I withdraw the authorization.

Authorized: _____ Date: _____
(Parent/Guardian)

Child's Name: _____
(Last) (First) (Middle)

School: _____ Grade: _____ Teacher: _____

Birthdate: _____ Sex: _____ Telephone: _____

Parent/Guardian Names: _____

Home Address: _____

Mother's Employment: _____ Telephone: _____

Father's Employment: _____ Telephone: _____

Doctor Preferred: _____ Telephone: _____

Doctor's Address: _____

Dentist Preferred: _____ Telephone: _____

Dentist's Address: _____

Insurance Company: _____ I.D. No.: _____

Important Medical Information

Allergies: _____

Current Medications or Treatments: _____

Previous Operations or Hospital Confinements: _____

_____

Other: _____