Union Local School District

Emergency Medical Authorization Form

Teacher_______________________________Grade _____________

Student Information

Student Name____Student Birth Date ______________

Parent/Guardian ____

Student Address ____Home Phone ____________________

Relative or Childcare Provider ____

Address ____ Phone _________________________

Health Information

Allergies____

Preferred treatment for allergies____

(If this includes medication of any type, please send a supply to the school nurse)

Chronic medical problems____

Medication taken every day____

Prior hospitalizations/surgeries____

Other health information the nurse should know____

(Please attach note if health history is lengthy)

Contact Information (Should your child become ill at school)

Please list contact information in the order you would like the calls to be made:

Name Relationship Phone Number

1.____

2.____

3.____

4.____

I hereby give consent for the following medical care providers and local hospital to be called:

Physician ____ Phone( )____________________

Dentist ____ Phone( )____________________

Emergency Room

Local Hospital ____ Phone( )____________________

I give permission for school personal to administer Tylenol or Tums as needed. Yes______ No________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by above-named doctors, or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and (2) the transfer of the child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery are obtained prior to performance of such surgery.

Parent Signature____Date____________________