AUTHORIZATION FOR EMERGENCY MEDICAL

Name:_______________________Date of Birth:_____________________ Today's Date:_____________

I/We, the parent(s) or legal guardian(s) of the above student, hereby delegates to Dundee Community Schools the authority to authorize and consent to any or all medical, surgical, dental, optical, hospital care, or treatment, in case of emergency, while on an educational field trip. Such treatment is to be rendered by, or under the jurisdiction of a duly licenses physician or dentist. Dundee Community Schools is fully authorized to act in accordance with best judgment in any such emergency and is absolved from any liability or financial responsibility to connection therewith.

____________________________________Home Telephone Number:_____________________

Signature of Parent/Guardian

Home Address:____

Mother/Father Place of Employment:____

Work Telephone Number:_____________________Cell Phone Number:____________________

Medical Insurance Company:_____________________Telephone No:______________________

Name of Subscriber:_______________________________Group No.:______________________

EMERGENCY INFORMATION

Please list any allergies your child has:____

Please note any special needs your child has (dietary, medical conditions, etc. Please attach a separate sheet if needed)

____

________________________	______________________	_________________
Name of Physician	Address	Telephone Number
________________________	______________________	_________________
Name of Dentist	Address	Telephone Number
________________________	______________________	_________________
Name of Eye Doctor	Address	Telephone Number

If unable to contact parent/guardian, please call (local contact):

________________________	______________________	_________________
Name/Relationship	Address	Telephone Number