EMERGENCY MEDICAL AUTHORIZATION PERMIT

Please complete each year if there is new information.

Should I become incapacitated and unable to authorize the delivery of emergency medical care, diagnoses, and treatment, including surgical intervention, if necessary, I authorize the individuals listed below to act on my behalf.

This authorization is valid until such time as I withdraw the authorization.

Authorized Person ____

Telephone Number ________________________________

Authorized Person ____

Telephone Number ________________________________

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: ____

______________________________________ __________________________________

Name (Print or type) __________________________________

Date of Birth__________________________ _____________________________________

Number Street Apt# City State Zip____

Signature_____________________________________ Date ________________________

This authorization will be maintained in a secure file in the Principal's Office and the Superintendent's Office until such time that it is needed and/or updated. Authorizations will be destroyed upon receipt of new information.