

LIVERPOOL CENTRAL SCHOOL DISTRICT

EMERGENCY MEDICAL TREATMENT AUTHORIZATION INFORMATION

(Required for trips in excess of 50 miles one-way or 5 hours duration)

TO WHOM IT MAY CONCERN: I, the undersigned, being the parent, legal guardian or next-of-kin hereby authorize any necessary medical treatment for:

(Pupil Name) (DOB) (Address)

City, State, Zip

In regard to such pupil, I submit the following information:

1. Allergies to foods, medication, etc. (if none, so state; if yes, specify): _____
2. Special medical problems (If none, so state; if yes, specify): _____
3. Is this student now under medical care? _____ If so, describe the nature of illness and treatment: _____
4. Does this student carry medication on person? _____
Purpose: _____
5. Date of last tetanus: _____
6. Family physician/clinic: _____
Phone: _____ Office Address: _____

Signature of Parent / Legal Guardian: Date

Printed or typed name of person signing above: Relationship to pupil:

Telephone: _____ Bus. Mother _____

Bus. Father _____ Cell Mother _____

Cell Father _____

Emergency name(s) and number(s) if above are not available: _____

Insurance Company: _____ Policy # _____

*Sworn to and subscribed before me this

_____ day of _____, 2006

Notary Public