

**STAFF EMERGENCY MEDICAL AUTHORIZATION**

School Building \_\_\_\_\_ School Address \_\_\_\_\_

Employee Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Home Address \_\_\_\_\_

City, State \_\_\_\_\_ Zip code \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Emergency Contacts**

Contact \_\_\_\_\_ Contact \_\_\_\_\_

Relationship \_\_\_\_\_ Relationship \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

**Medical Information**

Doctor \_\_\_\_\_ Phone \_\_\_\_\_

Dentist \_\_\_\_\_ Phone \_\_\_\_\_

Specialist \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Hospital \_\_\_\_\_

Allergies \_\_\_\_\_

Medical Conditions \_\_\_\_\_

Medications \_\_\_\_\_

Other Medical Information \_\_\_\_\_

I hereby give my consent in the event that all reasonable attempts to contact my emergency contact person have been unsuccessful for:

- (1) The administration of any treatment deemed necessary by my above named Doctor or Dentist or in the event that the preferred physician is not available, by another licensed physician or dentist, or paramedic unit, and
- (2) My transfer to the above noted preferred hospital or any hospital reasonably accessible.

Date \_\_\_\_\_ Signature \_\_\_\_\_