NLCS-150
Rev. 05/12

# EMERGENCY MEDICAL AUTHORIZATION PERMIT

Whenever my child is involved in a school activity and I am unavailable or otherwise unable to provide authorization directly, I grant to the school principal or his/her designee the authority to act for me and to provide any required consents and authorization for the delivery of emergency medical care, diagnoses, and treatment, including surgical intervention, if necessary, on behalf of my minor child listed below and to do all other necessary things as I might or could do to provide for the child=s health and safety, if I were present. This authorization is valid for the current school year or until such time as I withdraw the authorization.

Child's Name________________________________________________________________________

School______________________________ Grade_______ Teacher____________________________

Birthdate _______________________ Sex________ Home Phone# _____________________________

Parent/Guardian ___________________________________________Cell phone_________________

Home Address_______________________________________________________________________

Father's employment______________________________ Work phone_________________________

Mother's employment_____________________________ Work phone _________________________

Emergency contact__________________________Relationship____________Phone_______________

Emergency contact__________________________Relationship____________Phone_______________

Local physician preferred______________________________ Phone__________________________

Hospital preferred____________________________________________________________________

Insurance Company _____________________________ ID No. ______________________________

## Important Medical Information

Allergies___________________________________________________________________________

List All Current Medications_________________________________________________________

____________________________________________________________________________________

List all Medical Diagnoses and/or Chronic illnesses_______________________________________

____________________________________________________________________________________

Other______________________________________________________________________________

Authorized __________________________________________ Date _________________________

*Signature of parent/guardian*