BROOKFIELD CENTRAL SCHOOL

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT OF MINOR CHILD

Student Name: _____ Birthdate: _____

Address: _____

Telephone: _____

Allergies/Medications: _____

Hospitalization Coverage: _____

Name of Insurance Co./Gov't. Program: _____

Identification or Contract Number: _____

Family Physician: _____ Telephone: _____

I/We, being the parent (s)/legal guardian (s) of the above named minor, do hereby appoint any designated school personnel or:

_____

Name Address Telephone

_____

Name Address Telephone

to act in my/our behalf in authorizing emergency medical, dental, or surgical care and/or hospitalization for the above named minor during the period of:

_____ to _____

_____ _____

Parent/Guardian Signature Date