Springboro Community City Schools EMERGENCY MEDICAL AUTHORIZATION

The purpose of this form is to enable parents/guardians to authorize the provisions of emergency treatment for children who become ill or injured while under school authority when parents cannot be reached and to authorize the release of medical information to school officials/employees who have responsibility for the student while the student is at school or school events and/or is being transported by the schools.

Student Name: Building: Grade Rm # Bus #: Address: Name: Daytime Phone: Cell Phone: S-Mail: @ Father's Name: Daytime Phone: Cell Phone: Building: Cell Phone: Cell Phone: Cell Phone: Building: Cell Phone: Cell: Cell Phone: Cell: Cell Phone: Cell: Cell	Student Information			-
Mother's Name: Daytime Phone: Cell Phone; 3-Mail: 3-Mail: 5-Mail: 5-Mail: 5-Mail: 6-Mail: 7-Mail: 8-Mail: 8-Mai	Student Name:	Building:	Grade Rm #_	Bus #:
S-Mail:	Address:	Home Phone:		e of Birth
Tather's Name:	Mother's Name:	Daytime Phone:	Cell Phone:	
### Daystime Phone: Cell Phone: Cell Phone: Stather a legal custody order that applies to this child? (Please circle) Yes or No (If yes, please give details: Emergency Contacts (will be called in the order given if parent/guardian CAN NOT be reached) 1. Name: Relationship: Phone: Cell: Cell: Phone: Phone: Pax: Preferred Physician: Phone: Fax: Phone: Phone: Phone: Fax: Phone: Fax: Phone: Fax: Phone: Fax: Phone: Fax: Phone: Phon	E-Mail:@			
Other's Name:	Father's Name:	Daytime Phone:	Cell Phone:	
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Devised 1/10/11

Building Office

Copies:

School Nurse

Teacher

Transportation