OTSELIC VALLEY CENTRAL SCHOOL DISTRICT

AUTHORIZATION FOR MEDICAL TREATMENT - EMERGENCY INFORMATION

Dear Parent or Guardian: School accidents and illnesses must be anticipated. First aid is limited by the school to FIRST TREATMENT ONLY. The responsibility for further treatment rests upon the parent or guardian. Therefore, we need the following information:

Student Name: _____ Date: _____

Street Address: _____ Date of Birth: _____

City, State & Zip Code: _____ Grade: _____

Phone Numbers: Home: _____ Cell Number: _____

Father's Name: _____ Mother's Name: _____

Work #: _____ Work #: _____

Place of Employment: _____ Place of Employment: _____

List **four** emergency phone numbers & names in case the parents or guardian cannot be reached of who will oversee the care of your child.

1.) Name: _____ **2.**) Name: _____

Phone #: _____ Phone #: _____

Address: _____ Address: _____

3.) Name: _____ **4.**) Name: _____

Phone #: _____ Phone #: _____

Address: _____ Address: _____

Other than the above, list persons with permission to pick up your child: _____

Physician's Name: _____ Phone #: _____

Address: _____

Allergies to foods, medication, etc. (If none, so state) _____

Special Medical Problems (If none, so state) _____

Treatment: _____

Dentist Name: _____ Phone #: _____

Address: _____

***EMERGENCY CLOSINGS: In the event of an emergency closing, my child is to (check one):**

(_) Go home as usual (_) Go to the home of _____ Phone #: _____

Parent\Guardian Signature: _____ Date: _____

Copies to: Nurse (2) Student File Parent\Guardian (mailed)