DONNA
INDEPENDENT SCHOOL DISTRICT

EMERGENCY AUTHORIZATION

LAST NAME: _____ FIRST: _____ Date: _____

To the designated teachers-in-charge:
In the event, in your opinion, my child requires emergency medical treatment, you have my permission, and I hereby designate you, my agent, to call the following doctors after you have tried to telephone me and have been unsuccessful.

DOCTOR:_____ ADDRESS: _____

TELEPHONE: _____

In the event that your doctor cannot be reached, you have my permissions, and I hereby designate you my agent, to call any regularly licensed physician in the area of the trip itinerary.

I hereby release you from any claim arising out of the doctor's actions and I assume and agree to pay the doctor's charge for any services rendered at the doctor's direction.

PARENT/GUARDIAN SIGNATURE _____

ADDRESS _____

PHONE_____BUSINESS/CELL PHONE _____

Please list below the names of neighbors, relatives or friends who may be contacted if the parent is not available:

Name: _____ Name: _____

Address: _____ Address: _____

_____ _____

Telephone: _____ Telephone: _____

Students are not permitted to hold any medication (prescription or over the counter) on the trip. If your child must have medication during the trip, please contact the school nurse at # _____for the necessary forms and instructions.

Check **YES** or **NO**. (If YES, please explain, using the other side of the sheet if necessary.

1. Does the student have any allergies to medication, foods, etc.? □ YES □ NO
2. Are there any physical conditions of which we should be aware? □ YES □ NO
3. Does your child have an allergic reaction to insect/bee stings? □ YES □ NO

Insurance Company #_____Policy # _____

Revised: 4-17-23