SHAWNEE PUBLIC SCHOOLS

Authorization for Emergency Care

Student Name_____Date of Birth_____

Parent(Guardian) Name_____

Complete Address_____

Home Phone_____Cell Phone_____Work Phone_____

When parent can't be reached, notify:

Name_____Phone #_____

Family Doctor's Name_____Phone #_____

Preferred Hospital_____Phone #_____

Is student covered by Health Insurance? YES NO
Is pre-certification required for emergency care? YES NO

Name of Policy Holder_____
Name of Insurance Co._____
Policy/Membership #_____
Group #_____
Insurance Co. Phone Number for Pre-certification_____

Please list any medications you may be taking regularly:

Medication	Dosage	Frequency
1.		
2.		
3.		

KNOWN ALLERGIES OR OTHER VITAL INFORMATION:

_____I GIVE CONSENT FOR THE SPONSOR TO USE THEIR BEST JUDGMENT IN SECURING MEDICAL AID AND AMBULANCE SERVICE IN CASE RESPONSIBLE PARTIES CANNOT BE CONTACTED.

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PARENT SIGNATURE DATE