

MEDICAL EMERGENCY AUTHORIZATION FORM

Name of Student: _____

School: Lynden Christian High School

As parent or legal guardian, I authorize a qualified physician to examine the above named student and in the event of injury to administer emergency care and to arrange for any consultation by a specialist, including a surgeon, he deems necessary to insure proper care of any injury or illness. Every effort will be made to contact parent or guardian to explain the nature of the problem prior to any involved treatment.

Name: _____

Date: _____

(Signature of Parent or Guardian)

Parent/Guardian(father): _____ Home: _____ Work: _____ Cell: _____

Parent/Guardian(mother): _____ Home: _____ Work: _____ Cell: _____

Emergency Contact: _____ Home: _____ Work: _____ Cell: _____

Family Physician's Name _____ Phone Number _____

Family Insurance Company _____ Policy Number _____

Yes No

Does Student have any potentially life-threatening condition/allergy? Example: allergy to medication, bee sting, or food, seizures, diabetes, heart condition, if yes please explain condition and treatment.

Yes No

Is student taking any medication /treatment at this time? Example: asthma inhaler, etc.
