

**Minford Local School District
Emergency Medical Authorization Form
Part I**

School _____ **Grade** _____ **Student's Name** _____

Street Address _____ **City, State & Zip** _____

Telephone Number (with area code) _____ **Birthdate** _____

Purpose - - To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority, when parents or guardians cannot be reached.

Residential Parent or Guardian

Mother's First & Last Name _____

Mother's Daytime Phone (with area code) _____

Father's First & Last Name _____

Father's Daytime Phone (with area code) _____

Other Contact Person's First & Last Name _____

Other Contact Person's Daytime Phone (with area code) _____

Name of Relative or Childcare Provider

_____ **Relationship to Child** _____

Street Address _____ **City, State & Zip** _____

Daytime Phone Number (with area code) _____