BISHOP GRIMES JR./SR. HIGH SCHOOL
6635 Kirkville Road
East Syracuse, New York 13057
(315) 437-0356

AUTHORIZATION FOR EMERGENCY TREATMENT OF MINORS FORM

Name of Student:_____ Birth Date:_____

I/We being the parent(s) or legal guardian(s) of the above named student do hereby allow a qualified medical person to act in my/our behalf in authorizing medical, dental surgical care and hospitalization for the above named student in the event I cannot be reached.

PARENT OR GUARDIAN	PARENT OR GUARDIAN	PARENT OR GUARDIAN
_____	_____	_____
Signature	Signature	Signature
_____	_____	_____
Address	Address	Address
_____	_____	_____
State Zip	State Zip	State Zip
_____	_____	_____
Home Phone Work Phone	Home Phone Work Phone	Home Phone Work Phone

Please list below, special medical problems including allergies, etc.

_____
_____If none(X)_____

OVER

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Please list below, special medical problems including allergies, etc.

_____
_____If none(X)_____

OVER

STUDENT_____

HOSPITALIZATION COVERAGE FOR THE ABOVE NAMED STUDENT

NAME OF INSURANCE CO.OR GOV'T PROGRAM IDENTIFICATION OR CONTRACT#

FAMILY PHYSICIAN(S)

NAME PHONE# NAME PHONE#

This document shall be presented to a physician, dentist, or appropriate hospital representative at such time as emergency medical, dental, or surgical care or hospitalization may be required.

_____ _____

Name of Nearest Relative Name of Nearest Relative

Address_____ _____

_____ _____

Phone_____ Phone_____