MINOOKA COMMUNITY HIGH SCHOOL DISTRICT #111

MEDICAL AUTHORIZATION FORM

Student Name_____ Birth Date_____ Grade _____ Today's Date _____

Physician Name _____Office Number _____

Address _____
(Street) *(City)* *(State)* *(Zip)*

Father' Name _____ Mother's Name _____

Contact Number_____ Contact Number _____

Emergency Hospital: ❑ **Presence St. Joseph Medical Center** ❑ **Morris Hospital**
(Please check one)

Other Instructions _____

Allergies_____

My son/daughter will be carrying an asthma inhaler at school: ❑ Yes ❑ No

My son/daughter will be taking prescription medication during the school day: ❑ Yes ❑ No

If the parent(s)/guardian(s) and authorized physician(s) named above cannot be reached in the event of an emergency and if immediate observation or treatment is urgent in the judgment of the school authorities, do you authorize and direct the school authorities to send your child (properly accompanied) to the hospital or doctor? ***(Please check one)*** ❑ Yes ❑ No

_____
Parent/Guardian (Print)

_____ _____
Parent/Guardian Signature ***Date***

_____
Emergency Contact Number