BUFFALO PUBLIC SCHOOLS
CAREER & TECHNICAL EDUCATION

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EMERGENCY MEDICAL TREATMENT AUTHORIZATION FORM

Student Name:

Parent/Legal Guardian Name*: Relationship: Phone Number:

Parent/Legal Guardian Name*: Relationship: Phone Number:
*At least one required

If unable to contact parent/guardian, please contact:

Name*: Relationship to Student: Phone Number:

Name*: Relationship to Student: Phone Number:
*At least one required

Student's Physician: Phone Number:

If student is taking any regularly prescribed medication, is allergic to any medication, or if there is any other emergency information we need to know, please indicate below:

In the event of an accident or illness, I hereby grant permission to authorized personnel to provide first aid to my son/daughter. In the event of an emergency, if reasonable attempts to contact those named above prove unsuccessful, I hereby give consent to transport my son or daughter to the Emergency Medical Department of the nearest hospital. If his/her physician cannot be contacted, medical treatment deemed necessary by the attending licensed physician may be administered.

Parent/Legal Guardian Name:

Signature of Parent/Legal Guardian: _____

Date: ____/_____/_____