Work Based Learning Coordinator
Karen Noye
John Jay High School • Roy C Ketcham Highh\ School•Orchard View High School
845-897-6700• 845-298-5100

Emergency Medical Treatment Authorization

Name of Student: _____
Parent/ Legal Guardian: _____
Telephone of Parent/ Legal Guardian: _____
Address: _____

In case of emergency, if unable to contact parent listed above, please contact:

1. _____ Phone: _____ Relationship: _____

2. _____ Phone: _____ Relationship: _____

Student's Physician: _____ Phone: _____

Student's Dentist: _____ Phone: _____

If student is taking any regularly prescribed medication, is allergic to 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 for 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 or dentist may be administered.

Signature of Parent or Legal Guardian: _____

Date: _____