Chippewa Falls High School
Emergency Authorization Form

PLEASE PRINT

Student Name: _____ Date of Birth: _____ Grade: _____
(Last Name) (First Name) (Middle Initial)

In the event that emergency medical care is needed while my son/daughter is involved in extracurricular activities, I authorize the respective school personnel to transport him/her to a physician's office or emergency center. Further, I authorize the physician and hospital staff to treat my son/daughter as they deem necessary.

Parent/Guardian Signature _____ Date: _____

Medication presently taking _____

Known allergies to drugs and anesthetics _____

Father's Name: _____Home Telephone: _____ Work Telephone: _____

Father's Address: _____ Father's Employment: _____

Mother's Name: _____ Home Telephone: _____ Work Telephone: _____

Mother's Address: _____Mother's Employment: _____

Insurance Company and Number: _____

Family Doctor: _____ Telephone: _____

Family Dentist: _____ Telephone: _____