



High Meadow School

3643 Main Street
Stone Ridge, NY 12484
(845) 687-4855

EMERGENCY TREATMENT AUTHORIZATION

STUDENT NAME: _____
Last First Middle

ADDRESS: _____

HOME PHONE#: _____ DATE OF BIRTH: _____

ANY KNOWN ALLERGIES:

LIST MEDICATIONS (IF ANY): _____

PARENT/GUARDIAN: _____
NAME BUSINESS/DAY OR CELL PHONE #

E-MAIL ADDRESS: _____

PARENT/GUARDIAN: _____
NAME BUSINESS/DAY OR CELL PHONE #

E-MAIL ADDRESS: _____

PLEASE LIST TWO NEIGHBORS, FRIENDS OR RELATIVES **NEAR BY WHO WILL ASSUME TEMPORARY CARE OF YOUR CHILD IF YOU CANNOT BE REACHED.**

NAME: _____ NAME: _____

DAYTIME PHONE #: _____ DAYTIME PHONE#: _____

CELL PHONE #: _____ CELL PHONE #: _____

LOCAL HOSPITAL OF CHOICE: _____

DOCTOR: _____ PHONE # OF DOCTOR: _____

In the event that neither parent can be contacted in a serious emergency requiring medical attention, you have permission to take my child _____ to the Emergency Room and this note will serve as authorization for the Emergency Room Staff to take whatever steps necessary for the welfare of my child.

PARENT'S SIGNATURE: _____ DATE: _____