

## EMERGENCY TRANSPORTATION AUTHORIZATION

Name of Child		
Address		Phone
Mother's Name	Address	Phone
Employer's Name	Address	Phone
Father's Name	Address	Phone
Employer's Name	Address	Phone

If not at home or work, give telephone number where parents can be reached:

Mother (or Guardian) \_\_\_\_\_ Father (or Guardian) \_\_\_\_\_

**People to be contacted in the event of an emergency if the parent cannot be reached:**

Name		Name	
Address		Address	
City, State, Zip		City, State, Zip	
Relationship to Child	Phone	Relationship to Child	Phone

Name of Physician or Clinic		Name of Dentist or Clinic	
Address		Address	
City, State, Zip	Phone	City, State, Zip	Phone

Date of last physical exam: \_\_\_\_\_

**Medications** (prescriptions or over the counter) child is currently receiving. Please list the dosage, times of day medication is usually given and the reason for the medication. \_\_\_\_\_

**Any known allergies** \_\_\_\_\_

Special precautions and/or treatments for allergies \_\_\_\_\_

**(OVER)**

Chronic physical problems affecting child: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any other information the school should be aware of: \_\_\_\_\_

This Information was provided by (please print): \_\_\_\_\_

Signature of parent or guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**Complete either Part I or Part II below. Do not complete both.**

**Part I. Permission to transport child**

I give EL Christian Studies permission to transport my child to \_\_\_\_\_  
Hospital/Clinic  
for emergency care or to \_\_\_\_\_ for emergency dental care, or  
Dentist/Clinic  
to the nearest available source of assistance.

\_\_\_\_\_  
Parent's Signature Date

**Part II. Refusal to grant permission**

I do not give permission to EL Christian Studies to transport my child emergency medical or dental care. In the event of an illness or injury which requires emergency medical or dental treatment, I wish the following action to be taken:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Parent's Signature Date