YORKVILLE HIGH SCHOOL DISTRICT 115
Field Trip Emergency Medical Authorization

This form must be made available to the sponsor of all Yorkville High School approved trips to ensure proper medical treatment by physicians or hospitals in the event of a serious medical emergency.

Student's Name _____

Birth Date _____ Grade _____ Sex _____

Parent/Guardian Name _____

Home Phone _____ Work Phone _____ Cell Phone _____

Address _____ Zip _____

In the event the parents cannot be reached, please contact:

Name _____ Phone # _____

Date(s) of the event/trip: _____

Describe the activity the student will be participating in:

_____

_____

_____

I hereby give my consent for medical treatment deemed necessary by physicians designated by school authorities and/or for transportation to a hospital emergency room for treatment for any illness or injury.

Preferred Physician _____

Preferred Hospital _____

I understand this authorization will only be enforced when I cannot personally be contacted and provide for immediate treatment.

_____ _____
Parent/Guardian Signature Date

Any Medications: _____

_____

Known Allergies: _____

_____