

GLOVERSVILLE ENLARGED SCHOOL DISTRICT  
GLOVERSVILLE, NY 12078

**EMERGENCY INFORMATION  
AUTHORIZATION FORM**

(PLEASE PRINT AND PRESS DOWN)

Student's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Grade \_\_\_\_\_ Teacher \_\_\_\_\_ Date of Birth \_\_\_\_\_

Father's Name \_\_\_\_\_ Home address \_\_\_\_\_ Phone \_\_\_\_\_

Place of employment \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Home address \_\_\_\_\_ Phone \_\_\_\_\_

Place of Employment \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

**Brother & Sisters**

**Teacher's & Grades**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Emergency Contact Person(s) & Relationship:**

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**IF NONE OF THE ABOVE CAN BE REACHED, I WILL ALLOW MY CHILD TO BE TRANSPORTED TO THE EMERGENCY ROOM BY AMBULANCE FOR MEDICAL TREATMENT AS NECESSARY. I REALIZE THAT THE SCHOOL DISTRICT CAN NOT ASSUME RESPONSIBILITY FOR THE PAYMENT OF MEDICAL FEES INCURRED.**

**My child has the following medical condition, which requires these steps to be followed in case of Emergency.**

Pediatrician's Name \_\_\_\_\_ Pediatrician's Ph# \_\_\_\_\_

Pediatrician's Fax \_\_\_\_\_

\_\_\_\_\_  
PARENT SIGNATURE

\_\_\_\_\_  
DATE