OCMBOCES
Committed to Your Success

AUTHORIZATION for EMERGENCY TREATMENT of MINORS

Name of Minor: ____

Date of Birth:____________________________

I/We, being the parents(s) or legal guardian(s) of the above named minor, do hereby appoint **Onondaga Cortland Madison BOCES** to act in my /our behalf in authorizing emergency medical, dental, surgical care and hospitalization for the above named minor during the period of my/our absence during the 2019 – 2020 school year and/or Summer School 2020.

This document shall be presented to the physician, dentist or appropriate hospital representative at such a time as emergency medical, dental, surgical care, or hospitalization may be required.

Name of Parent/Guardian: (print) ____

Signature of Parent/Guardian: ____

Address: ____

City: ____________________________ State: ___________________________ Zip:____________________

Phone: ____

WITNESSED BY: (signature) ____

Hospitalization coverage for the above named minor:

Insurance Company or government program: ____

Identification or contact number: ____

Family Physicians: ____

Alerts:

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