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 2020 – 2021 school year and/or Summer School 2021.

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:

_____

_____