Students

Exhibit – Authorization for Medical Treatment Form

To be submitted to the Superintendent

Student:	
Sport/Activity:	Date of Birth:
Home Address:	
Home Phone:	

TO WHOM IT MAY CONCERN: In the event reasonable attempts to contact me at the locations listed below have been unsuccessful, I, as parent or legal guardian of the above student, do hereby authorize (1) the treatment by a qualified and licensed medical doctor of my child/ward in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment or undue discomfort if delayed; and (2) the transfer of my child/ward to any hospital reasonably accessible.

This release form is completed and signed of my own free will with the purpose of authorizing medical treatment under emergency circumstances in my absence.

Name and relation to student:	
Address:	
Home Phone:	Business Phone:
Cell Phone:	Other Phone:

Emergency Contact::	
Home Phone:	Business Phone:
Cell Phone:	Other Phone:

Physician:	Phone:

Medical Information: *(list allergies, medications, conditions and any known restrictions)*

Parent/Guardian Signature: _____ Date:_____

APPROVED: July 14, 2008