Students - 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 are unsuccessful, I, as parent or legal guardian of the above student, do hereby authorize: (1) the treatment by a licensed medical physician 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 with the purpose of authorizing medical treatment under emergency circumstances in my absence. *(please print)*

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:

Allergies, Medicines, or Other Conditions: *(please list)*

Parent/Guardian Signature*:* _____ Date*:* _____