



To be completed by parent/guardian for each child and submitted to the school annually

**MEDICAL AND EMERGENCY NOTIFICATION INFORMATION
AUTHORIZATION FOR MEDICAL TREATMENT**

SCHOOL _____ SCHOOL YEAR _____

| STUDENT NAME | DATE OF BIRTH | GRADE | LIST MEDICAL ALLERGIES and/or SIGNIFICANT MEDICAL HISTORY |
|--------------|---------------|-------|---|
| | | | |

PLEASE PRINT

Parent/Guardian _____ Parent/Guardian _____

Home Phone _____ Work _____ Home Phone _____ work _____

Cell Phone _____ Cell Phone _____

Name of Student's Physician _____ Phone _____

Address _____ City _____ State _____

Medical Insurance Provider _____ Policy/Insurance# _____

EMERGENCY CONTACTS IN CASE PARENT/GUARDIAN CANNOT BE REACHED:

NAME _____ RELATIONSHIP TO STUDENT _____

Phone (1) _____ Phone(2) _____

NAME _____ RELATIONSHIP TO STUDENT _____

Phone(1) _____ Phone(2) _____

MEDICAL RELEASE

In the event that the undersigned, or my/our authorized physician, cannot be reached and in the judgment of the School Principal or his/her authorized staff member, there is a necessity for immediate examination and/or treatment of my/our child, I/we hereby request and authorize any of the aforesaid personnel to obtain for my/our child such medical services as are deemed necessary, I/We agree to assume the financial responsibility for any diagnosis/ treatment and/or for medication necessary.

PARENT /GUARDIAN SIGNATURE

DATE

PARENT/GUARDIAN SIGNATURE

DATE

THIS FORM WILL ACCOMPANY STUDENTS ON FIELD TRIPS, IT IS THE RESPONSABILITY OF THE PARENT/GUARDIAN TO UPDATE EMERGENCY INFORMATION AS NECESSARY.