EMERGENCY MEDICAL TREATMENT RELEASE FORM

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Student's Name: _____ Relationship to you: _____

Address: _____ Phone: _____

Type of activity or school year for which release is intended: _____

PARENTS/LEGAL GUARDIANS

_____

Father Address Phone

_____

Mother Address Phone

Where parents can be reached when not at home:

Father _____
Address Phone

Mother _____
Address Phone

Family Physician: _____ Phone: _____

Address: _____ City: _____

List allergies, medication, or other pertinent comments:

_____

_____

Health Insurance Data:

Company: _____ Policy: _____

Group: _____ Contract: _____

List a neighbor or close relative who will assume care of your child if you cannot be reached.

Name _____ Phone _____

Address _____ Relationship _____

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

Date: _____ Signed: _____
(Parent or Guardian)

Attention Parents: This form should be notarized.
Some medical facilities will only provide treatment if the signature is notarized.

NOTARY TO COMPLETE:

State of: _____

County of: _____

Subscribed and sworn to before me

This _____ day of _____ 19 _____

_____ Notary Public