

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 Name: _____ Relationship to you: _____

Address: _____ Phone: _____

PARENTS/LEGAL GUARDIANS

Where parents can be reached when not at home:

Father /Guardian	Place of Employment	Work Address
Father Work Phone # _____	Cell # _____	Beeper # _____
Home Email: _____	Work Email: _____	

Mother/Guardian	Place of Employment	Work Address
Mother Work Phone # _____	Cell # _____	Beeper # _____
Home Email: _____	Work Email: _____	

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: _____ Cell _____

Address: _____ Relationship: _____

Name: _____ Phone: _____ Cell _____

Address: _____ Relationship: _____

Name: _____ Phone: _____ Cell _____

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: _____ Parent/Guardian Signature: _____

- I further authorize the person who presents the minor to sign the Acknowledgement of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility.
- This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date: _____ Parent/Guardian Signature: _____