EMERGENCY MEDICAL INFORMATION

Please fill out the following form in the event your son/daughter is injured and needs emergency medical attention.

Name _____ Telephone _____

Parent/Guardian Names:

Father _____ Work Phone _____
Mother _____ Work Phone _____
Family Doctor _____ Phone _____
Dentist _____ Phone _____
Hospital Preference _____

Emergency alternate Contact in case parents CANNOT be reached:

Name _____ Phone(H) _____ (W) _____
Name _____ Phone(H) _____ (W) _____

Medicines allergic to: _____
Other Health factors: _____

_____ _____
Name of Insurance Company Policy Number

MEDICAL AUTHORIZATION

TO WHOM IT MAY CONCERN:

I, the undersigned being the parent or legal guardian of _____, do hereby grant to any hospital, emergency center, doctor, nurse and/or paramedic authorization to grant treatment to my child, when accompanied by or escorted to, the treating facility by a coach, faculty member or administrator of the Mulvane Public School District.

Further, should the attending physician determine after examination that life-saving procedures or surgery may be necessary, permission is hereby extended to the above parties to grant same.

Additionally, I agree to hold harmless such personnel and the Mulvane Board of Education by my action of granting said permission.

I declare under penalty of perjury that the above is true and correct.

_____
Date

_____
Signature of Parent or Guardian

Printed Name: _____
Address: _____

Telephone: _____