

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 _____ (W) _____

Name _____ Phone _____ (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: _____