SCHOOL: *EMERGENCY INFORMATION* 2018-19

*THIS FORM MUST BE FILLED OUT COMPLETELY

CHILD'S NAME_______________________________________ BIRTH DATE_____________________ GRADE_________

PARENT'S NAMES____

ADDRESS____HOME PHONE________________________________

CITY/ZIPCODE____

DAD CELL____ MOM CELL____

DAD EMAIL_______________________________________MOM EMAIL____

DAD WORK#______________________________________MOM WORK#_______________________________________

AUTHORIZED PICK-UP____

AUTHORIZED PICK-UP____

EMERGENCY CONTACT: 1.____CELL_________________________
(Other than parents)

2.____ CELL __________________________

3.____ CELL __________________________

CONSENT FOR EMERGENCY MEDICAL TREATMENT

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO REFORMATION LUTHERAN SCHOOL, TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A LICENSED PHYSICIAN (M.D.), OSTEOPATH (D.O) OR DENTIST (D.D.S.) FOR

____.
(Child's Name)

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

*****CHILD HAS THE FOLLOWING MEDICATIONS/ALLERGIES: *** (IF none, please write "NONE")**

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Signature of Parent or Authorized Representative Date