



SCHOOL: *EMERGENCY INFORMATION* 2019-20

***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")**

Signature of Parent or Authorized Representative

Date