



Hawken Upper School Emergency Medical Release Authorization

Purpose: To enable parents and guardians to authorize the provision of emergency treatment for students who become ill or injured while under school authority, when parents or guardians cannot be reached.

Student's Name _____

Date of birth _____ Grade level _____

Address _____ City _____ Zip _____

Home Phone _____

Parents:

Mother _____ Father: _____

Living with child? _____ Living with child? _____

Mother's Employer _____ Father's Employer _____

Mother's Work Phone _____ Father's Work Phone _____

Mother's Cell Phone _____ Father's Cell Phone _____

My child is permitted to stay home unattended if I am not home. Yes _____ No _____

Name of Medical Plan or Insurance Company _____

Name of Policy Holder _____

Group Number _____ Policy Number _____

Please list two alternate people to be contacted and who can assume custody if parent or guardian cannot be reached in an emergency or if the child is ill.

1. Name _____

Home Phone _____ Cell Phone _____

Relationship to child _____

2. Name _____

Home Phone _____ Cell Phone _____

Relationship to child _____

Signature of parent or guardian _____ Date _____

PLEASE COMPLETE THE REVERSE SIDE!

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PART 1: TO GRANT CONSENT

I hereby give consent for the following medical care providers and local hospital to be called:

Physician _____ Phone _____

Medical Specialist _____ Phone _____

Dentist _____ Phone _____

Local Hospital _____ Phone _____

In the event that reasonable attempts to contact me have been unsuccessful, I hereby give consent for (1) the administration of any treatment deemed necessary by the above named doctors, or, in the event that the designated preferred practitioner is not available, by another licensed physician or dentist and (2) the transfer of my child to any hospital reasonably accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Disabilities _____ Allergies _____

List Medications currently being taken _____

Date of most recent tetanus shot _____

Recent illness/injury/surgery _____ Activity restriction _____

Other _____

PART II: REFUSAL TO CONSENT (Do not complete if you completed Part I)

I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action: _____

Signature of Parent/Guardian _____ Date _____