May 2022 7:300-E3

# Students

## Exhibit - Authorization for Medical Treatment

*To be submitted to the Superintendent. (please print)*

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Student |  | Sport/Activity |
|  |  |  |
| Parent/Guardian |  | Home phone |
|  |  |  |
| Home address |  | Cell phone |
|  |  |  |
| Physician |  | Physician phone |
| Medical Information: *(list allergies, medications, conditions and any known restrictions)* | | | |

In the event of a medical emergency and if reasonable attempts to contact me using the telephone numbers listed above are unsuccessful:

I, as parent or legal guardian of the above student, do hereby authorize treatment by a licensed medical physician of my child in the event of a medical emergency that, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. I understand that transfer of my child to any hospital reasonably accessible will be at my expense.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| Parent/Guardian Signature |  | Date |