SCHOOL: *EMERGENCY INFORMATION* 2020-21

*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