2008 EMERGENCY MEDICAL TREATMENT RELEASE FORM

STUDENT LAST NAME	FIRST	MIDDLE	DATE OF BIRTH	AGE	SEX	GRADE

ADDRESS-NUMBER & STREET	CITY	ZIP	HOME PHONE NUMBER ( )

FATHER'S NAME: PLACE OF EMPLOYMENT:	BUSINESS PHONE ( )	CELL NUMBER ( )
MOTHER'S NAME: PLACE OF EMPLOYMENT:	BUSINESS PHONE ( )	CELL NUMBER ( )

PHYSICIAN'S NAME: ADDRESS:	CITY	ZIP	PHONE NUMBER ( )

** MEDICAL CONDITIONS/ALLERGIES- Please list all pertinent information we should be aware of:

** Please note: If your student needs to take medications during the school day either regularly or occasionally, an additional form must be completed. You may request one from the GR Attendance Office OR download a form from our website.

HEALTH INSURANCE COMPANY	MEMBER OR SUBSCRIBER NAME	
CONTRACT OR ID NUMBER	GROUP NUMBER	POLICY NUMBER OR PLAN CODE

EMERGENCY CONTACT NAME **(Not parent)**	RELATIONSHIP	HOME PHONE NUMBER ( )
ADDRESS	CITY	CELL PHONE NUMBER ( )

To Whom It May Concern:

As parent/guardian, I do hereby authorize the treatment of a qualified and licensed physician of any condition, which, in the opinion of the physician, is deemed necessary and appropriate. This authority is granted only after a reasonable effort has been made to reach me.

I further authorize the person who presents the minor to sign the Acknowledgement of Receipt of Notice Privacy Rights that may be presented by the physician or health care facility.

This authorization is completed and signed of my own free will with the sole purpose of authorizing medical treatment deemed necessary and appropriate by the treating physician.

Date:___________________________________ **Signed:**____

Parent or Guardian

excel:reg:medicalform