Emergency Action Permission
2017-2018

Name of Student: ______________________________________ Grade ____________

1. The school has my permission to call my family physician in an emergency in which I cannot be contacted, and my physician may render treatment necessary for the well-being of my child.

Name of Physician___________________________________ Phone________________

Allergic to medication (specify type)____

Other allergies, medical or other conditions of which the school and teachers should be aware:

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2. The school has my permission in an emergency in which I cannot be contacted, to take my child to the emergency room of the nearest hospital. The hospital and its staff have my authorization to provide treatment necessary for the well-being of my child.

Signature of Parent______________________________________ Date_____________

Insurance Carrier and ID# ____

Notes:

FOR OFFICE USE ONLY

ITEM	RECEIVED	ITEM	RECEIVED
Registration Form			
Confidential Form			
Emergency Action Permission			
Photo Release Form			