

WEST PRAIRIE CUSD #103  
AUTHORIZATION FOR MEDICAL TREATMENT FORM

High School       Middle School       South Elementary       North Elementary

Student: \_\_\_\_\_

Form to be submitted to Superintendent

Sport/Activity: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

To whom it may concern: In the even reasonable attempts to contact me at the locations listed below are unsuccessful, I, as parent or legal guardian of the above student, do hereby authorize: (1) the treatment by a licensed medical physician of my child/ward in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed, and (2) the transfer of my child/ward to any hospital reasonably accessible.

This release form is completed and signed with the purpose of authorizing medical treatment under emergency circumstances in my absence. *(please print)*

Parent Name: \_\_\_\_\_ Relationship to Student: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Other Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship to Student: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

Other Phone: \_\_\_\_\_

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Allergies, Medicines, Other Conditions: *Please List*

Parent/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_