WESTLAKE CITY SCHOOL DISTRICT
EMERGENCY MEDICAL & STUDENT RELEASE AUTHORIZATION

School Year_____

Student: _____Date of Birth: _____ Phone:_____

School: _____ Grade:_____ Homeroom Teacher_____

Address: _____ Email Address:_____

Please indicate if there are any changes in the above info. from the previous school year, excluding grade & teacher. YES___ NO___

Parent Signature_____

Purpose: To enable parents to authorize emergency treatment for children who become ill or injured while under school authorization, when parents cannot be contacted AND to grant consent for the children to be released to any of the following individuals.

Please X which type of release is authorized, Emergency Medical Only, Student Release, or Both

Print Full Name	Home Phone	Work Phone	Cell Phone	*Medical*	*Release*
Mother:	( )	( )	( )		
Father:	( )	( )	( )		
Other Responsible Person (Relationship)	( )	( )	( )		
Other Responsible Person (Relationship)	( )	( )	( )		
Other Responsible Person (Relationship)	( )	( )	( )		
Other Responsible Person (Relationship)	( )	( )	( )		

PART 1 or PART 2 MUST BE COMPLETED

PART 1 – TO GRANT CONSENT

In the event reasonable attempts to contact me at the above numbers have been unsuccessful, I hereby give my consent for: (1) the administration of any treatment deemed necessary by:

Dr. _____, PHONE (_____)_____(preferred physician),

Dr. _____, PHONE (_____)_____(preferred dentist),

Or in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and **(2)** the transfer of the child to preferred hospital: ☐ St. John Westshore ☐ Fairview ☐ Lakewood

If the emergency is such that your child needs immediate attention, he/she will be taken to the most accessible of these hospitals. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of the surgery, are obtained before the surgery is performed.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairment to which a physician should be alerted:

_____

_____

Date:_____ Parent Signature:_____

If You Completed Part 1 Above – Do NOT Complete Part 2

PART 2 – REFUSAL TO CONSENT

In the event reasonable attempts to contact me at the above numbers have been unsuccessful, I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action, or to:

_____

_____

Date:_____ Parent Signature:_____