



CAMPUS / SCHOOL _____

EMERGENCY MEDICAL INFORMATION AND AUTHORIZATION

CHILD'S NAME _____

MEDICAL INFORMATION:

Please list any special problems that your child may have, including allergies, existing chronic conditions such as diabetes, seizures, heart condition or asthma:

Please list any medication that your child takes on a regular basis: _____

Physician's Name: _____

Address: _____ Phone: _____

Emergency Care Facility Name: _____

Address: _____ Phone: _____

AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION:

In the event that I cannot be reached to make arrangements for emergency medical attention, I authorize the site leader or person in charge to take my child to the nearest medical facility by ambulance or private vehicle. I give consent for necessary emergency treatment when my child is in the care of a physician and/or a hospital or clinic. In addition, I agree and do hereby waive and release all claims against the GISD, teachers, employees, or other person engaged in the activity in which my child was injured. I agree to hold them harmless from any and all liability relating to my child for any personal injury or illness that may be suffered or any loss of property that may occur to my son/daughter. I have read this release and understand its terms. I voluntarily sign this form with full knowledge of its significance, and with the intention of binding myself.

SIGNATURE PARENT OR LEGAL GUARDIAN

DATE