SILVERTON HIGH SCHOOL BANDS

MEDICAL RELEASE

Dear Parent,

This form may be used in the event that your child requires medical attention and you cannot be contacted. If YOUR CHILD'S PHYSICIAN cannot be reached, or if a physician feels the child should be treated in an Emergency Room, this completed form will accompany your child.
I,____, certify that I am the Parent/Legal Guardian of
the following child: ____
Name Date of Birth

AUTHORIZATION TO TREAT A MINOR

In the event of an emergency, I, the undersigned parent/guardian do hereby authorize the district to obtain any medical care or hospitalization of my child, as they believe necessary for the welfare of my child. I do further authorize any medical doctor or hospital to provide any treatment believed necessary for immediate care of my child. I, the undersigned agree to pay for such medical treatment and shall hold Silver Falls School District 4J harmless from any liability, claims, judgments, and costs incurred as a result of any such medical treatment or hospitalization.

This authorization is effective NOW through June, 2014.

Health Insurance Co:______________________________________ Group number:__________________
(In the interest of ease, it would be advisable that your student carries their Health Insurance information card or photo copy with them at all times.)

Physician:____ Phone #:__________________________

Date of last Tetanus Shot: ________________________

- Please list any allergies (bee sting, medications, latex, etc.), illnesses or conditions that the adults traveling with your student should be aware of:____
  ____
- If your student is currently taking ANY prescription medications, they all must be listed below:
  ____
  ____
- If my child becomes unwell and requests non-prescription medicines (such as Ibuprophen, etc.), I hereby give my permission for an adult to provide it to them. I have listed any exceptions to this below:____

____
Parent/Guardian Signature Date