## Delaware Christian School - Emergency Medical Release Form

Grade__________ Student Name________________________________________

Address________________________________________

Telephone________________________________________

Purpose - to enable parents and guardians to authorize emergency treatment for students who become ill or injured while under school authority, when parents or guardians cannot be reached.

Mother's Name_________________________ Daytime Phone____________________

Father's Name_________________________ Daytime Phone____________________

Name of relative or child care provider________________ Relationship______________

Address________________________________________ Phone____________________

**Part 1 or 2 Must be Completed**

Part 1 - To Grant Consent

I hereby give consent for the following medical care provider and local hospital to be called:

Doctor____________________________________________ Phone________________

Dentist____________________________________________ Phone________________

Medical Specialist____________________________________ Phone________________

In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) any treatment deemed necessary by above named physician or dentist; in the event the designated preferred practitioner is not available by another licensed physician or dentist: and (2) the transfer of student to the nearest available hospital. The authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists concurring in the necessity for such surgery.

Please check all that apply to your child:

__on medicine(If so, what?)__________(for what?)_________

__diabetes

__asthma (Medication taken)________________

__epilepsy

__heart condition

__allergies __bee stings __foods(list)_______________________

__medications(list)___________________

__physical limitations (please explain)____________________________________________

__hearing loss

__vision loss

__other (please explain)______________________________________

________________________________________________________________________

**(Date)** **Required: (Signature of Parent/Guardian)**

Part 2 - Refusal to Consent

I do *NOT* give my consent for medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take the following action:

________________________________________________________________________

________________________________________________________________________

**(Date)** **(Signature of Parent/Guardian)**

**Please copy the front and back of your health insurance card and attach to this form.**