

## Students

### Exhibit – Authorization for Medical Treatment

*To be submitted to the Superintendent. (please print)*

\_\_\_\_\_  
Student

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

\_\_\_\_\_  
Parent/Guardian

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

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

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

\_\_\_\_\_  
Physician

\_\_\_\_\_  
Physician Phone

Medical Information: *(list allergies, medications, conditions and any known restrictions)*

In the event of a medical emergency and if reasonable attempts to contact me using the telephone numbers listed above are unsuccessful:

I, as parent or legal guardian of the above student, do hereby authorize:

1. Treatment by a licensed medical physician of my child/ward in the event of a medical emergency that, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed, and
2. Transfer of my child/ward to any hospital reasonably accessible at my expense.

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

\_\_\_\_\_  
Date