CENTRAL BUCKS SCHOOL DISTRICT

Name: _____ _____
(Last name) (First Name)

Permission for Emergency Medical Treatment

In the event of an emergency requiring medical attention, I hereby grant my permission to any licensed physician, hospital, personnel, or other trained, professional medical personnel to attend to my son/daughter.

_____
(Print Participant's Name)

I expect an effort will be made to contact me in order to receive my specific authorization before any treatment or hospitalization is undertaken, however, my authorization should not preclude essential medical care.

Parent/Guardian Signature: _____ Date: _____

Please Print the Following:

Parent/Guardian Name: _____

Address: _____

_____

Home Phone Number: _____

Emergency Phone Number: _____

Family Doctor: _____

Phone Number: _____

Medical Insurance Plan: _____

Medical Insurance Policy Number: _____

Please list any specific medical conditions, and or instructions: _____

_____

_____