

# Medical Authorization

Dear Parent:

In the event that your son/daughter is injured while in attendance in one of our programs, every effort will be made to contact you. We have on occasion experienced difficulty in contacting parents/guardians of students during an emergency. The law requires that written permission must be obtained from the parent/guardian before any type of medical treatment can be administered to the student. The law also requires that we obtain parent consent to release emergency contact and medical history information to an off-campus training site of your son/daughter.

We are, therefore, requesting a signed medical authorization form by the parent/guardian to be held on file in our campus office. Your signature, unless noted otherwise, also gives your consent to release emergency contact/medical history information to an off-campus training site.

Thank you for your cooperation in this matter. If you should have any questions, please feel free to call our office at: \_\_\_\_\_ . Please direct your inquiry to the attention of: \_\_\_\_\_.

Should it be necessary for my child to have medical treatment while participating in the Academy program, I hereby give the school district personnel permission to use their judgement in obtaining medical service for my child. I give permission to the physician selected by the school district personnel to render medical treatment deemed necessary and appropriate by the physician. Permission is also granted to release emergency contact/medical history to an off-campus training site for my child.

Student Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Telephone: \_\_\_\_\_ Address: \_\_\_\_\_

Work Telephone: \_\_\_\_\_

Contact Person Other than Parent/Guardian: \_\_\_\_\_

Relation to Student: \_\_\_\_\_ Telephone: \_\_\_\_\_

**OR**

\_\_\_\_\_ I do not wish to give medical release.

\_\_\_\_\_ I do not wish to have my child's emergency contact/medical history released.

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_