



SCHOOL EMERGENCY INFORMATION 2020-21

This form must be filled out completely

CHILD'S NAME _____ BIRTH DATE _____ GRADE _____

PARENT'S NAMES _____

ADDRESS _____ HOME PHONE _____

CITY/ZIPCODE _____

DAD CELL _____ MOM CELL _____

DAD EMAIL _____ MOM EMAIL _____

DAD WORK# _____ MOM WORK# _____

AUTHORIZED PICK-UP _____

AUTHORIZED PICK-UP _____

EMERGENCY CONTACT: 1. _____ CELL _____

(Other than parents)

2. _____ CELL _____

3. _____ CELL _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

AS THE PARENT OR AUTHORIZED REPRESENTATIVE, I HEREBY GIVE CONSENT TO REFORMATION LUTHERAN SCHOOL, TO PROVIDE ALL EMERGENCY MEDICAL OR DENTAL CARE PRESCRIBED BY A LICENSED PHYSICIAN (M.D.), OSTEOPATH (D.O) OR DENTIST (D.D.S.) FOR:

(Child's Name)

THIS CARE MAY BE GIVEN UNDER WHATEVER CONDITIONS NECESSARY TO PRESERVE THE LIFE, LIMB OR WELL BEING OF THE CHILD NAMED ABOVE.

*****CHILD HAS THE FOLLOWING MEDICATIONS/ALLERGIES: *** (If none, please write "NONE")**

Signature of Parent or Authorized Representative _____ **Date** _____