

Medical Permit for Treatment

Student's Name: _____ Grade: _____

Medicaid: No ___ Yes ___ # _____ Birth Date: _____

Insurance: No ___ Yes ___ Policy Name & Number: _____

Resides with: _____ Phone # _____

Address: _____

Work Phone:
(Father's): _____ (Mother's): _____

Physician Name: _____ Phone: _____

Person to notify if unable to contact parent/guardian:

Name: _____ Relationship: _____

Phone #: _____ Work Phone: _____

I hereby give permission for staff members of the Amboy School District #272 to seek emergency medical attention for the above named student. I understand that an attempt will be made to contact me or the alternative emergency person first but if contact can not be made I authorize treatment for the best interest of the above named student.

I also give permission for staff members to administer first aid.

Please list ANY MEDICAL INFORMATION that the school, doctor, or hospital personnel should be aware of such as asthma, diabetes, epilepsy, etc.

1. _____

2. _____

3. _____

Please list any current medications that the student is taking:

1. _____

2. _____

Please list any known allergies to medications, foods, etc.

I agree to have this information shared with appropriate school personnel and agree to have my child seek medical attention if an emergency arises.

Signature of parent or guardian: _____ Date: _____