

EMERGENCY MEDICAL RELEASE FORM

ALL information must be completed FULLY before child attends school.

CHILD'S NAME (print) _____

DATE OF BIRTH _____ **ALLERGIES** _____

If my child is injured or becomes violently ill at school and I,
(print) _____, cannot be reached at **home**:

Phone hm _____ cell _____

Address _____ **City** _____ **Zip** _____

OR

Mother's Name _____

Mother's **Employer**: _____

Phone work _____ cell _____

Address _____ **City** _____ **Zip** _____

OR

Father's Name _____ **Phone** _____

Father's **Employer**: _____

Phone wk _____ cell _____

Address _____ **City** _____ **Zip** _____

Concordia Lutheran School staff may seek emergency treatment for my child. It is understood that every effort will be made to first contact parents before any action is taken. I understand the church and staff do not bear the responsibility for any medical costs incurred, and that I shall be solely responsible for these costs. I hereby give my permission to the school to seek emergency medical treatment for my child, and for my child to be transported to the nearest medical facility.

Parent Signature _____ **Date** _____

Please list information regarding persons YOU authorize to take your child from school:

NAME _____ NAME _____

Phone hm: _____ cell: _____ Phone hm: _____ cell: _____

Address _____ Address _____

City _____ Zip _____ City _____ Zip _____

EMERGENCY INFORMATION

Doctor _____ **Phone** _____
Address _____ **City** _____ **Zip** _____

Hospital of Choice _____ **Phone** _____
Address _____ **City** _____ **Zip** _____

Dentist _____ **Phone** _____
Address _____ **City** _____ **Zip** _____

Emergency Contact Name _____ *1st Choice (other than parents)*

Relationship to child _____

Phone: hm: _____ cell: _____

Address _____ **City** _____ **Zip** _____

Emergency Contact Name _____ *2nd Choice*

Relationship to child _____

Phone: hm: _____ cell: _____

Address _____ **City** _____ **Zip** _____

