

MELISSA M. STILLEY  
SUPERINTENDENT

ROBIN T. ABRAMS  
BOARD PRESIDENT



TANGIPAHOA PARISH SCHOOL SYSTEM  
PERMISSION FOR EMERGENCY TREATMENT

DATE \_\_\_\_\_

To Whom It May Concern:

\_\_\_\_\_ School has my permission to seek emergency medical treatment for my child, \_\_\_\_\_, in the event I cannot be reached. My child may be taken to the nearest medical facility in the event my doctor, \_\_\_\_\_, telephone number, \_\_\_\_\_ is not available. In case of an emergency, I will be responsible for any bill incurred while receiving treatment and transportation.

**ATTENTION:**

**IT IS THE RESPONSIBILITY OF THE PARENT OR LEGAL GUARDIAN TO CONTACT THE SCHOOL NURSE WHEN A STUDENT HAS A MEDICAL CONDITION OR HEALTH PROBLEM. THIS MUST BE DONE AT THE BEGINNING OF EVERY SCHOOL YEAR, OR AS SOON AS THE PARENT/GUARDIAN BECOMES AWARE OF THE STUDENT'S CONDITION. THIS WILL ENABLE YOU TO DISCUSS WITH THE NURSE THE CARE YOUR CHILD MAY NEED AT SCHOOL.**

PARENT/GUARDIAN'S SIGNATURE: \_\_\_\_\_

HOME ADDRESS: \_\_\_\_\_

HOME TELEPHONE NUMBER: \_\_\_\_\_

WORK TELEPHONE NUMBER: \_\_\_\_\_

EMERGENCY TELEPHONE NUMBER: \_\_\_\_\_

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