Student Private Physician Card

Student Name _____
(Last) (First) (Middle)

Home Address _____

City _____

********** For students in high school only**********

Physician's Name _____

Physician's Number _____

Parent's Home Number _____ Work _____

_____

Please list any problem(s) that the teachers should be aware of:

In case of an accident or serious illness, if the school is unable to contact us, I hereby authorize the school to take my son/daughter to the physician above for the treatment and I will not hold the school or physician liable for their actions. If it is impossible to contact the physician, the school may take my son/daughter to a hospital authorized by the Board of Health for treatment.

Parent or Guardian: _____