

# Emergency Medical Release

Student Name: \_\_\_\_\_

School year: \_\_\_\_\_

I give my permission for my child to receive emergency medical treatment if my child is injured or becomes ill while participating in a high school/jr. high school program or activity. It is understood that such permission is granted only if lack of medical treatment could cause deterioration or aggravation of a child's condition.

This permission covers this year only unless revoked by written notice.

## Health History

	Yes	No
Asthma	_____	_____
Concussion	_____	_____
Diabetes	_____	_____
Heart Condition or Disease	_____	_____
Kidney Injuries	_____	_____
Surgeries	_____	_____

Parent/Guardian Signature: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Date Signed: \_\_\_\_\_