Munising Baptist School

EMERGENCY TREATMENT RELEASE FORM

(one per student -- please fill in ***all*** blanks)

FAMILY INFORMATION	
Name of Student:	Grade:
Home Phone:	Date of Birth:
Father's Name: Cell Phone: Place of Employment: Work Phone:	
Mother's Name: Cell Phone: Place of Employment: Work Phone:	
MEDICAL INFORMATION	
Family Physician:	Phone:
Preferred Hospital:	City:
Health Screening Survey: ***PLEASE COMPLETE THE BACK SIDE***	
LOCAL EMERGENCY CONTACTS List two responsible adults, who in the case of an emergency, will assume responsibility for your child if parents cannot be reached	
Name: Address: Relation:	Home Phone: Work Phone:
Name: Address: Relation:	Home Phone: Work Phone:

As a parent and/or legal guardian, I do herewith authorize the treatment by a qualified and licensed medical doctor of the above named minor in the event of a medical emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after reasonable effort has been made to reach me. Necessary first aid may be given by the school. This release form is being completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.

Parent's Signature: ______________________________ Date: ______________

HEALTH SCREENING SURVEY – CONFIDENTIAL

(please fill in all blanks and sign)

Chronic Health Conditions:

Asthma ______
Seizure Disorder ______
Diabetes ______
Skin Conditions ______

Attention Problems:
ADD ______
ADHD ______

Vision Problems:

Wears Glasses ______
All the time? ______
Contact Lenses ______
Other Concerns ______
____

Hearing Problems:

Frequent ear infections ______
Tubes ______
Known hearing loss ______
Other Concerns ______
____

Does your child have any allergies to any of the following:

Medications: Y N ____
What type of medication

Food: Y N ____
Please specify what types of food

____
Please specify what type of reaction to the food

Other: ____

Does your child take medication on a daily basis: Y N

Name & dosage of medication:____

Will your child be taking medication at school: Daily ______ or As Needed ______

Other health concerns:____
____

Please notify the school office if there are any changes in your child's health during the school year. Keeping our records as current as possible is important to our staff and your child's well being.

Y N I/We give permission for the school to request aid of the closest Rescue Unit in the event of a serious accident, injury, or illness.

____ ________________
Parent/Guardian Signature Date