



**PARENT NOTIFICATION  
EMERGENCY MEDICAL & STUDENT RELEASE AUTHORIZATION**

**MAIN CONTACTS:** In case of an emergency with your student, the school office will call and notify you at the primary phone number provided. If you are not reached at the primary number, phone calls will be made to the contacts and phone numbers listed below in the order given until someone is notified. Automated attendance calls are used at LHS.

Child's Name \_\_\_\_\_ Grade \_\_\_\_\_ Primary Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_

★ West Shore Program \_\_\_\_\_ ★

**Place an X in one or both columns at the far right for the contacts for whom you allow to authorize emergency medical treatment for your student and to whom your student may be released.**

Print Full Name	Home Phone	Work Phone	Cell Phone	Emergency Medical	Student Release
1 <sup>st</sup> Contact/Relationship	( )	( )	( )		
2 <sup>nd</sup> Contact/Relationship	( )	( )	( )		
3 <sup>rd</sup> Contact/Relationship	( )	( )	( )		
4 <sup>th</sup> Contact/Relationship	( )	( )	( )		

**PART 1 – TO GRANT CONSENT**

**In the event reasonable attempts to contact me at the above numbers have been unsuccessful, I hereby give my consent for:**

**(1)** the administration of any treatment deemed necessary by:

(Physician) Dr. \_\_\_\_\_, Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

(Dentist) Dr. \_\_\_\_\_, Address \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_

Or in the event the designated preferred practitioner is not available, by another licensed physician or dentist: and

**(2)** the transfer of the child to preferred hospital:  Lakewood  Fairview

If the emergency is such that your child needs immediate attention, he/she will be taken to the most accessible of these hospitals. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of the surgery, are obtained before the surgery is performed.

**Facts concerning the child's medical history including allergies, medications being taken, food supplements, modified diets, fluoride supplements, and any physical impairment to which a physician should be alerted:** \_\_\_\_\_

Date: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

Student Last Name \_\_\_\_\_

Student First Name \_\_\_\_\_



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**If You Completed Part 1 On Page 1 – Do NOT Complete Part 2 in Box Below**

***PART 2 – REFUSAL TO CONSENT***

**In the event reasonable attempts to contact me at the above numbers have been unsuccessful, I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the school authorities to take no action, or to:**

Date: \_\_\_\_\_ Parent Signature: \_\_\_\_\_

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Student Last Name \_\_\_\_\_

Student First Name \_\_\_\_\_

