

MEDICAL RELEASE AND RESPONSIBILITY

This information is required and must be filled in by a Parent/Guardian.

All students enrolled are required to have this form on file in the High School or Elementary Office.

	Name of Student	Grade	Allergic to OR Health Conditions
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____
5	_____	_____	_____

PARENTAL / LEGAL GUARDIAN RELEASE FOR MEDICAL CARE

I, _____, authorize employees of Sheridan School District No. 5: Facility and staff members, coaches, advisors or administration in charge of students to obtain all necessary medical care and authorize any licensed physician and/or medical personnel to render treatment to my son(s)/daughter(s).

Parent Signature

Date

PARENT / LEGAL GUARDIAN INFORMATION

DAD / Legal Guardian's Name _____

Mailing Address _____

Phones:

Home: _____

Work: _____

Cell: _____

MOM / Legal Guardian's Name _____

Mailing Address _____

Phones:

Home: _____

Work: _____

Cell: _____

NON PARENT EMERGENCY CONTACT INFORMATION

In the case of an emergency, **if a parent / legal guardian cannot be reached**, the following people can be contacted:

Name: _____

Relationship: _____

Phones:

Home: _____

Work: _____

Cell: _____

Name: _____

Relationship: _____

Phones:

Home: _____

Work: _____

Cell: _____

INSURANCE CARRIER: _____

Group Name: _____

Group I.D. # _____

or Employee I.D. Number: _____

Insurance Co. Address: _____

City: _____

State: _____

Zip: _____