SHERIDAN PUBLIC SCHOOLS

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			

PARENTAL 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 INFORMATION

DAD / Guardian's Name _____

Mailing Address _____

Phones:
Home: Work: Cell:

MOM / Guardian's Name _____

Mailing Address _____

Phones:
Home: Work: Cell:

NON PARENT EMERGENCY CONTACT INFORMATION

In the case of an emergency, **if a parent/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: