Elizabethtown Independent Schools

MORNINGSIDE AFTER SCHOOL CARE PROGRAM

EMERGENCY MEDICAL TREATMENT RELEASE FORM

Child's Name: ____ Date: _______________

Birthdate: ____

All Known medicine, food, or other allergies____________________________________

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Chronic or recurrent illness or disorders: _______________________________________

Medication for the above; please state the name and dosage________________________

Will the medication need to be given during program hours? If yes, when will it need to

be given? No____ Yes ____ ____

What should we do if your child has a problem related to his/her medical condition

during program hours? ____

Family Physician's Name: ____

Physician's Office Phone: ____

Physician's Office Address: ____

Preferred Hospital;____

I, THE PARENT/GUARDIAN, GIVE PERMISSION FOR EMERGENCY MEDICAL OF THE CHILD NAMED ABOVE. I UNDERSTAND THAT IF SUCH TREATMENT IS NEEDED I WILL BE NOTIDIED AS SOON AS POSSIBLE.

PARENT/GUARDIAN SIGNATURE: _______________________________________

Home Phone: __________________________ Work Phone: ________________________

If unable to reach you by phone, please give person and phone number for us to call:

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Name Relationship Phone #