

NORTH HIGH SCHOOL EMERGENCY AND INSURANCE FORM

PURPOSE – To enable parents and guardians to authorize the provision of emergency treatment for children who become ill or injured while under school authority when parents or guardians cannot be reached.

Name _____ Grade _____

Address _____

Telephone _____

School _____

Coach _____

Date of Birth _____

Parent or Guardian (Residential)

Mother _____ Daytime Phone _____

Father _____ Daytime Phone _____

If we are unable to contact you is there a relative or friend we may call?

Name _____ Phone _____

Name _____ Phone _____

Name _____ Phone _____

I hereby give consent for the following medical care providers and local hospital to be called

Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Specialist _____ Phone _____

Local Hospital _____ Phone _____

****PART I OR II MUST BE COMPLETED****

PART I – TO GRANT CONSENT

In the event reasonable attempts to contact me at home or work or other parent at home or work have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by previously named physician or dentist of my preference, 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 or any hospital reasonable accessible. This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained prior to the performance of such surgery.

Facts concerning the child's medical history including allergies, medications being taken, and any physical impairments to which a physician should be alerted.

Signature of Parent/Guardian _____ Date _____

Part II – REFUSAL TO CONSENT

*****DO NOT SIGN PART II IF YOU SIGNED PART I*****

I do not give 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 _____

Signature _____ Date _____

INSURANCE FOR INTERSCHOLASTIC ATHLETICS

The student _____ (name)
is covered by the following medical policy.

Name of Company _____

Policy Number _____

Certified by: _____
(parent signature)

In case of injury, while participating in interscholastic athletics, we, the parents/guardians, will assume full responsibility for any claims resulting from said injury and we will not hold the Willoughby-Eastlake Schools or any of the school personnel responsible for medical costs.

Date _____

Parent/Guardian Signature _____

Address _____

Phone _____

