

Please PRINT clearly!

Your name _____ Year of Graduation 2012 2013
Address _____ 2014 2015
City _____ Zip _____ Phone # (home) _____
Your E-mail _____ Your Phone # (cell) _____

People to call if you are ill, or in case of emergency:

Mother _____	Phone _____	Phone _____	Student lives with" (please check boxes)
Father _____	Phone _____	Phone _____	[]
Stepmother _____	Phone _____	Phone _____	[]
Stepfather _____	Phone _____	Phone _____	[]
Guardian _____	Phone _____	Phone _____	[]

Your parent's e-mail address: _____

Emergency Medical Authorization

In the event that reasonable attempts to contact me or the other parent/guardian have been unsuccessful, I hereby give my consent (1) for the administration of any treatment deemed necessary by our preferred physician or dentist, or in the event that the designated preferred practitioner is not available, by another licensed physician or dentist, and (2) for the transfer of the child to our preferred hospital or any hospital reasonably 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 before surgery is performed.

Preferred Doctor _____ Phone # _____
Preferred Dentist _____ Phone # _____
Preferred Hospital _____

Facts concerning the student's medical history, including allergies, medications being taken, and any other impairment to which a physician should be alerted.

Parent signature _____ Date _____

Do not complete this if your completed the Emergency Medical Authorization

I do NOT give my consent for emergency medical treatment of the above student. In the event of illness or injury requiring treatment, I wish the school authorities to take no action, or to:

Parent signature _____ Date _____