



**2019-2020 LIMITED POWER OF ATTORNEY FOR EMERGENCY MEDICAL CARE  
AND/OR RELEASE OF STUDENT TO EMERGENCY CONTACT**

**TO WHOM IT MAY CONCERN:**

I \_\_\_\_\_ (the natural parent(s) or legal guardian)  
Print

hereby give permission that my child, \_\_\_\_\_  
First Middle Last

may be given emergency treatment to include first aid and CPR by a qualified emergency medical or first aid caregiver. I further authorize and consent to medical, surgical and hospital care, treatment and procedures to be performed for my child by a licensed physician or hospital when deemed immediately necessary or advisable by the physician to safeguard my child's health. I waive my right of informed consent to such treatment. I also give permission for my child to be transported by ambulance or aid car to an emergency center for treatment.

Name \_\_\_\_\_  
Signature Relationship Date

Witness \_\_\_\_\_ Date \_\_\_\_\_

**Emergency Contacts:**

Name	Relationship	Phone Number	Cell Phone	Auth. to pick up
_____	_____	_____	_____	<input type="radio"/>
_____	_____	_____	_____	<input type="radio"/>
_____	_____	_____	_____	<input type="radio"/>
_____	_____	_____	_____	<input type="radio"/>

**(OVER)**

Student Home Address \_\_\_\_\_  
Number and Street City State Zip Code

Home Phone \_\_\_\_\_ Student's Birth date: \_\_\_\_\_

Insurance Company \_\_\_\_\_

Policy/Membership Number \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder Name \_\_\_\_\_

Employer Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Employer Address \_\_\_\_\_  
City State Zip Code

**Medical Information:**

Please list all known Allergies \_\_\_\_\_

Does your student have a Pre-Existing Illness? Please list \_\_\_\_\_

Does your student take medication? \_\_\_\_\_

Please list the medication your student takes \_\_\_\_\_

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**Please make sure that you carefully and legibly completed this form. This form will be used for multiple reasons.**

