Exhibit – Authorization for Medical Treatment

To be submitted to the Superintendent or designee. (please print)

Student	Sport/Activity
Parent/Guardian	Home phone
Home address	Cell phone
Physician	Physician phone

Medical Information: *(list allergies, medications, conditions and any known restrictions)*

In the event of a medical emergency and if reasonable attempts to contact me using the telephone numbers listed above are unsuccessful:

I, as parent or legal guardian of the above student, do hereby authorize:

1. Treatment by a licensed medical physician of my child in the event of a medical emergency that, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed, and
2. Transfer of my child to any hospital reasonably accessible at my expense.

Parent/Guardian Signature	Date

Cross Reference:
PRESS 7:300-E3, *Authorization for Medical Treatment*