STUDENT'S NAME: _____
Please print! (LAST) (FIRST) (MIDDLE INITIAL)

MID-OHIO DISTRICT YOUTH COUNCIL
EMERGENCY MEDICAL RELEASE FORM

Address: _____ Birth Date: _____

City/Zip Code: _____ Grade: _____ Age: _____

PURPOSE: To enable parents or guardians to authorize the provision of any emergency treatment necessary for children who become ill or injured while under our authority, when parents or guardians cannot be reached. We will make every effort to contact you or other persons whose names you give as contacts before going any further.

PARENT/GUARDIAN(S) AND EMERGENCY CONTACTS

(List 2 contacts minimum)

CALL ORDER	NAME *(First & Last)*	RELATIONSHIP	HOME PHONE	CELL PHONE	CAN PICK-UP?

PERMISSION GRANTING MY CONSENT:

In the event that reasonable attempts to contact the above have been unsuccessful, I hereby give my CONSENT for administration of treatment deemed necessary by:

Family Doctor:_____Phone: _____

Family Dentist: _____ Phone: _____

Eye Doctor: _____ Phone: _____

Hospital: _____ Phone: _____

In the event that my designated physician, dentist or ophthalmologist is not available, I hereby give my consent for treatment by any licensed physician, dentist or ophthalmologist. YES _____ NO _____

In the event that my designated hospital isn't reasonably accessible, I hereby give my consent for treatment by the nearest local hospital. YES _____ NO _____

It is extremely important that you provide ANY pertinent medical history, allergies (including food), physical impairments, or other information about existing conditions that may affect your child.

Medical Information: _____

_____

Medications: _____

Allergies: _____

Signature of Parent/Guardian: _____ Date: _____