EMERGENCY RELEASE FORM

Student ID #: ___________________

Name of Student: ______________________________ ______________________________ Birthdate: ____________________
Last First

Home Address: ____ Zip: ___________ Phone: _______________________

Father's Contact Information: Name: ____

Phone: Home: _________________________ Work: ________________________ Cell: ________________________

Email: ____

Mother's Contact Information: Name: ____

Phone: Home: _________________________ Work: ________________________ Cell: ________________________

Email: ____

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Please list the names of people that are authorized to pick up and transport your child in the case of a personal emergency or community disaster. Please list as many as possible.

NAME	ADDRESS	PHONE	RELATIONSHIP

If you have a telephone number of a relative living out of state who could receive a message, please fill in below:

____________________________________ ___________________________ __________ ____________________________
Name Relation Area Code Phone Number

I hereby authorize the school to release my child to any of the above persons if I'm not available

PARENT/GUARDIAN SIGNATURE: ____ DATE: ____________________

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AUTHORIZATION OF CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD

I (We) authorize Centennial Middle School, an adult who resides at 305 E 2320 N Provo, Utah 84604, to consent to any X-ray, examinations, anesthetic, medical or surgical diagnosis or treatment and hospital care, to be rendered to the minor under general or special supervision and on the advice of physician or surgeon licensed to practice in the state of Utah, when the need for such treatment is immediate, and when efforts to contact me (us) are unsuccessful. I agree to assume all financial responsibility for services provided my child. This is to be effective upon the date of any occurrence requiring the exercise of power of attorney, unless revoked by me in writing. This authorization shall not be affected by my death or disability.

PARENT/GUARDIAN SIGNATURE: ____ DATE: ____________________

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The following information could be vital to emergency medical care personnel in case of a community disaster:

Child's doctor or medical group: ____ Phone: ___________________________

Does your child have any chronic illnesses or allergies/asthma? Yes ________ No ________

Explain: ____

Is your child allergic to any medication? Yes ________ No ________

Name(s): ____

Is your child currently taking any medications? Yes ________ No ________

Name(s): ____

Other concerns: ____

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