MACNEAL SCHOOL—AUGUST 2011-AUGUST 2012

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

Student's Name: _____ **Date of Birth:** _____/_____/_____

Address: _____
street address **apt/unit #**

_____
city **state** **zip**

Parent/Guardian Daytime Phone: _____

Primary Physician: _____

Address: _____ **Phone:** _____
street address **suite/office number**

_____
city **state** **zip**

Known Allergies: _____

_____

Chronic Illnesses/Medical Problems: _____

_____

I, _____, Parent/Guardian of _____,
and having custody of same, do hereby agree to the following authorizations:

1. I authorize a physician to perform the procedures that may be necessary for the emergency diagnosis and treatment of the above named student while currently in the program at MacNeal School in the event I am unable to be contacted or am unavailable for immediate written or telephone authorizations.
2. I authorize MacNeal School to release the above medical information, which is relevant to the emergency examination and treatment.
3. I authorize that a photocopy of this authorization be accepted with the same authority as the original.

I, _____, understand that MacNeal School cannot assume financial liability for expenses incurred for transportation and during an emergency room visit.

_____ _____
Parent/Guardian Signature **Date**