EAU CLAIRE AREA SCHOOL DISTRICT— MIDDLE SCHOOLS

Authorization for Emergency Transportation and Treatment

Student's Name (Print) _____ Grade _____

Last First MI

Date of Birth _____ Sports: Q1 _____Q2 _____Q3 _____ Q4 _____

Medical Insurance Company_____ Ins. #_____

Medications presently taking _____

Known allergies _____

Father's full name _____ Home # _____ Work # _____

1. I authorize school personnel to transport my child to a physician's office and/or emergency room for treatment in the event that emergency medical care is needed. Further, I authorize the PHYSICIAN and HOSPITAL STAFF to treat my child as they deem necessary in any emergency situation.
2. I attest to the fact that the above named student/athlete has not been hospitalized or suffered any serious illness or injury since the time of his/her last physical examination.
3. I fully realize that the school does not provide any insurance coverage.

_____ _____ _____

(Parent Signature) (Date) (Student Signature) (Date) (Coach Initials)