



## Emergency Information & Authorization

Student's Last Name First Name Sex M/F Grade D.O.B.

Street Address City, Zip Home Phone Day Phone

Fathers Name Phone Cell Phone

Mother's Name Phone Cell Phone

In case of accident or injury I expect Good Shepherd Lutheran School to follow policy during school and extended care hours. In case you are unable to reach me during any emergency, you are authorized to contact and, if necessary, release my child to any of the following: (I understand that my child will not be released to anyone than those listed below)

Name Relationship Phone number

Name Relationship Phone number

Name Relationship Phone number

Name Relationship Phone number

Name Relationship Phone number

In the event of emergency, I hereby give my permission and consent for my child to be treated at an accredited emergency hospital and release the school and driver from any liability. I grant full authority to the principal or staff member in charge to order emergency medical treatment as recommended by competent medical authority. \_\_\_\_\_ Initials

Name of Doctor Address Phone

Name of Insurance Insurance Number Phone Number

Medication to be taken during school hours must be brought to the school office along with the written consent from the parent or guardian. Medications must be clearly labeled with the students full name, doctors name and phone number, name of medication, dosage and schedule. Aspirin or Tylenol will be administered to student only if written consent has been given.

I wish to give authorization to give Tylenol. \_\_\_\_ Yes \_\_\_\_ No.

Please list food allergies for your child or write NONE \_\_\_\_\_

I agree to all of the above:

Parent/ Guardian Signature

Date

