ST CLAIR COUNTY SCHOOLS

MEDICAL FORM (2)

I give my permission to have my child treated by the school nurse and administered first aid. I understand that all reasonable precautions will be taken for my child's safety, and I will not hold the school or employees responsible for any illness or unforeseen accident.

Student's Doctor Phone Number of Doctor

Address of Doctor

Hospital Choice

Insurance Company Insurance Number

I, the undersigned, do hereby authorize the officials of the St. Clair County School System to contact directly the persons named on this paper, and to authorize the named physician(s) to render such treatment as may be deemed necessary in an emergency, for the health of my child. In the event that the physicians(s), other persons named on this paper, or parents cannot be contacted, the school officials are hereby authorized to take whatever action is deemed necessary, In their judgment, for the health of my child. I will not hold the school financially responsible for the emergency care and/or transportation of my child. Every attempt will be made to reach the parent or emergency contact person listed.

I agree to allow the school nurse to exchange medical information with physician, dentist, physician assistant or emergency medical personnel In order to provide medical care for my child.

Signature of Parent/Guardian

Please notify the school nurse of any changes In health status, new surgeries, or special needs for your child.