

Emergency Release Form

In the event of a serious accident or illness with my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, and I cannot be reached, I hereby authorize the school to contact the physician or dentist and for those professionals listed below to provide protected health information.

|  |  |  |
| --- | --- | --- |
| Physician / Dentist Name | Phone Number | Address |
|  |  |  |
|  |  |  |

In the event of an EMERGENCY I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ understand that ABELS Academy will call the 911 Emergency Medical System immediately. To expedite care I give my permission for the school to provide medical information to the responding emergency team to initiate treatment, and transport to the nearest appropriate facility. I give my permission for the appropriate medical personnel and staff to initiate treatment upon arrival to the appropriate facility. I request to be notified of my child’s condition and admission as soon as possible. If I cannot be reached, I request that the admitting facility notify one of the other persons listed of my child’s condition and admission. I agree to be financially responsible for my child’s treatment and transport.

I have reviewed the above information and give permission to:

* Call Doctor
* Call 911
* Ride in Ambulance if needed
* Treat

My Emergency Contacts if I am not available in order of who to call first is:

|  |  |  |  |
| --- | --- | --- | --- |
| Last Name | First Name | Relationship | Phone Number |
|  |  |  |  |
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Parent Signature Date

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Print Parent’s Name