

LAKESIDE SCHOOL

PERMISSION FOR EMERGENCY TREATMENT/MEDICAL INFORMATION FORM

Effective August 13, 2010 - August 12, 2011

RELEASE FOR EMERGENCY MEDICAL TREATMENT

If a student suffers a medical emergency (e.g., serious injury or illness) while at school or while involved in a school-sponsored activity off campus, Lakeside School makes every reasonable effort to contact and inform a parent/guardian before treatment is undertaken. Lest emergency medical care be delayed, parents/guardians are asked to sign the following release authorizing emergency treatment.

Student Name: \_\_\_\_\_ Grade: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Gender: \_\_\_\_\_

(I)(We), the undersigned, parent(s)/legal guardian(s) of \_\_\_\_\_, a minor, do hereby authorize that my child be given emergency medical treatment to include first aid and CPR by a qualified staff member. (I) (We) authorize Lakeside School, in the event of a medical emergency, to contact Seattle's Medic I, a licensed ambulance service, or a legal representative (employee) of the school, to transport my student to the emergency facilities of Northwest Hospital or any duly licensed and accredited medical hospital. (I) (We) authorize said physician or surgeon to examine the above-named student to administer emergency medical care and to arrange for any consultation by a qualified specialist necessary to insure proper care of any injury.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian (print): \_\_\_\_\_ Home phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Family Physician's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Medical Insurance: \_\_\_\_\_ Policy Number: \_\_\_\_\_

MEDICAL INFORMATION—INCLUDING PHYSICIAN'S SIGNATURE Please provide the following medical background information.

Preexisting medical conditions (if any): \_\_\_\_\_

Please indicate whether/if so when student has suffered a concussion: \_\_\_\_\_

Allergies to medicine (if any): \_\_\_\_\_

Environmental/Food allergies (if any): \_\_\_\_\_

Medications taken on a regular basis (if any): \_\_\_\_\_

Medications student may use occasionally (as needed) \_\_\_\_\_

Does student wear glasses?  Yes  No Contacts?  Yes  No Immunizations up to date?  Yes  No

Date of most recent vaccine for tetanus \_\_\_\_\_

Attach most recent immunization record to this form

Student may participate in  physical education  competitive athletics  outdoor program  student activities

Limited/restricted participation (describe) \_\_\_\_\_

DATE OF MOST RECENT PHYSICAL \_\_\_\_\_ Where performed \_\_\_\_\_

Doctor's name (print) \_\_\_\_\_

Doctor's signature \_\_\_\_\_ Date \_\_\_\_\_