

Authorization FOR EMERGENCY MEDICAL TREATMENT

I, The undersigned, am the parent/legal guardian of _____, a GCHS student, who resides with me at the address shown hereinafter, and who attends Garden City High School (Unified School District #457, 1205 Fleming, Garden City, Ks 67846.)

I hereby give my consent, in the event all reasonable attempts to contact me at _____ (phone #) or _____ (other parent or guardian) at _____.

List allergies and current medications: _____

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1. A staff member of the aforesaid school to request medical or dental assistance or treatment for my child which may be necessitated by virtue of participation in a school-sponsored or related activity;
 2. The administration of any treatment deemed necessary by Dr. _____ (preferred physician) or, Dr. _____ (preferred dentist), or in the event the appropriate preferred practitioner is not available, by another licensed physician or dentist;
 3. Medical coverage _____ Policy # _____,
Group # _____, no coverage _____ Insurance Phone # _____.
 4. The transfer of the student to St. Catherine Hospital, 410 E. Walnut, Garden City, Ks or any hospital reasonable accessible.

This authorization does not cover major surgery unless the medical opinion of two other licensed physicians or dentists concurring in the necessity for such surgery are obtained to the performance of such surgery.

This authorization and consent shall be effective for the school year commencing in August/September, 20 _____.

Dated _____, 20 _____.

Parent or Legal Guardian

***Participation in athletics may result in injury to your child.**

Address