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: ____
____

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