EMERGENCY CONTACT AND RELEASE FROM SCHOOL INFORMATION

Student's name _____
(last) (first) (middle)

Home address _____
(city) (zip code)

Home telephone _____ Cellular _____ Beeper_____

E-mail _____

Emergency Contact Information: Occasionally, an accident or extreme illness of a student makes it necessary for school personnel to contact the parent to get permission for emergency referral. Additional data is needed in case of an emergency illness of your child. The legal responsibility for medical and transportation expense incurred on behalf of your child is a parental one.

_____
(Mother's Name) (Place of Employment) (Occupation) (Phone)

_____
(Father's Name) (Place of Employment) (Occupation) (Phone)

_____
(Guardian's Name) (Place of Employment) (Occupation) (Phone)

If parent can't be reached, whom should we try to contact?

1. _____
(Name) (Relationship to Student) (Home Phone) (Work Phone)

2. _____
(Name) (Relationship to Student) (Home Phone) (Work Phone)

RELEASE OF STUDENT FROM SCHOOL INFORMATION:
List below those **persons authorized** to take your child from school during the school day including parents' names.

_____

If any person is **not authorized** to take the student from school, please indicate below.

_____

YOUR CHILD WILL NOT BE RELEASED TO ANY PERSON NOT LISTED ABOVE.

It is the Parents' responsibility to inform the school of any changes in the information listed on this card.

Date: _____ Parent's signature_____

IMPORTANT: Any medications which are to be taken must be registered with Irene Recio.

(continued on back)

STUDENT EMERGENCY DATA
AUTHORIZATION FOR MEDICAL TREATMENT

1. I am the (father) (mother) (legal guardian) of the minor children listed below:

Name(s) of child(ren)	Date of birth

2. The children reside with me at _____
(COMPLETE STREET ADDRESS WITH ZIP CODE)

3. From time to time, I place one or more of my children listed above in the care and custody of the following individuals:

Name	Address	Relationship	Telephone

4. Any known allergies (to medication or otherwise) and medication my children are presently taking are as follows:

Name(s) of child(ren)	Allergies or known allergic reactions	Present medication

5. Provided the medical care and treatment of any one or more of my children is on the advice of a licensed physician, I authorize and request all physicians, hospitals or other providers of medical services to follow the instructions of any person listed in the preceding paragraph 3 at any time and under any circumstances whatsoever.

6. The children are covered (if applicable) under the following group medical plan:

Employer	Insurance company	Plan number

7. The children's doctor is:

Name of doctor	Address	Telephone

STATE OF FLORIDA
COUNTY OF _____
Sworn to and subscribed before me _____
Authorized Parents' Signature

_____
Notary Public, State of Florida at Large

Personally Known _____ or Produced Identification _____

Type of Identification Produced _____

OF THE DADE COUNTY BAR ASSOCIATION AND APPROVED BY THE DADE COUNTY BAR ASSOCIATION THIS AUTHORIZATION FOR MEDICAL TREATMENT WAS PREPARED BY THE PROBATE AND GUARDIANSHIP COURT COMMITTEE OF THE DADE COUNTY BAR ASSOCIATION AND THE SOUTH FLORIDA SOCIETY FOR HOSPITAL RISK MANAGEMENT. THIS AUTHORIZATION IS A PUBLIC SERVICE OF THE DADE COUNTY BAR ASSOCIATION.