

## MOSCOW PUBLIC SCHOOLS--MEDICAL RELEASE FORM

I hereby appoint USD 209, Moscow, Kansas, coaches, sponsors, teachers, nurses, or administrators, as my agent and representative for the purpose of authorizing and consenting to hospital care and/or medical care and treatment of \_\_\_\_\_ for any illness or injury that may occur while in the care of the leader throughout the \_\_\_\_\_ school year. It is understood that all possible means will be taken to contact the parents/guardian before treatment is given. This release is for emergency treatment if the parents/guardian are unable to be contacted.

I also consent to the release of this student's immunization information to the Kansas Immunization Registry.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Witness Signature

Student's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Mailing Address \_\_\_\_\_ Home Phone # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Father's Name \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Physician's Name \_\_\_\_\_ Hospital Preference \_\_\_\_\_

Prescriptions Taken Daily \_\_\_\_\_

\_\_\_\_\_  
ALLERGIES

\_\_\_\_\_  
Health Problems

\_\_\_\_\_  
EMERGENCY NUMBERS TO BE CALLED IF UNABLE TO REACH  
PARENT/GUARDIAN

Name \_\_\_\_\_ Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Name \_\_\_\_\_ Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_