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 # _____