



Holy Martyrs ARS Ashkhen Pilavjian Preschool 2017-2018 School Year



Child's Name: _____

Group: _____

Health Insurance Policy # _____

Name of Company: _____

Dental Insurance Policy # _____

Name of Company: _____

CONSENT FOR MEDICAL TREATMENT & EMERGENCY TRANSPORTATION

As the parent or legal guardian, I hereby give consent to Holy Martyrs ARS Ashkhen Pilavjian Preschool ("School") to provide all emergency dental or medical care prescribed by duly licensed physician (MD) or dentist (DDS) as appropriate for This care may be given under whatever conditions necessary to preserve the (Child's Name) life, limb or well being of my dependent. The School will also arrange for emergency transportation (Ambulance or other vehicle) to the nearest medical facility if deemed necessary by School staff. I agree to hold the School harmless for taking any actions authorized hereunder.

Medical Alert: Condition..... Medication

Condition Medication

Name of Physician _____

Phone Number _____

Emergency Release Information

Student's Name: Phone:

Address:

Mother's Name: Mobile Phone:

Father's Name: Mobile Phone:

I authorize the release of my child to the following people during an emergency or regular pick up.:

NAME	PHONE	RELATIONSHIP
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		

I understand that emergency information is required by the School for the release and treatment of my child for any problem requiring possible action. It is my responsibility to provide written notifications to the School immediately of any change.

Parent/Guardian Signature:

Date:

The student was released to (Relationship)

Time of release Date of release Destination

Staff verification Signature